UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

TRUST BOARD

MEETING TO BE HELD ON MONDAY 8 JANUARY 2015 FROM 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Public meeting commences at 9am

AGENDA

Please take papers as read

Item no.	Item	Paper ref:	Lead	Discussion time
1.	**APOLOGIES AND WELCOME**	**-**	**Chairman**	
	To receive apologies for absence from Professor D Wynford-Thomas, Non-Executive Director. To welcome Ms E Stevens, Acting Director of Human Resources to the meeting.			
2.	**DECLARATIONS OF INTERESTS**	**-**	**Chairman**	
	Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the public agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
3.	**MINUTES**			
	Minutes of the 22 December 2014 Trust Board meeting. *For approval*	**A**	**Chairman**	-
4.	**MATTERS ARISING**			
	Action log from the 22 December 2014 meeting. *For approval*	**B**	**Chairman**	9am – 9.05am
5.	**KEY ISSUES FOR DECISION/DISCUSSION**			
5.1	**PATIENT STORY** *For discussion*	**C**	**Deputy Chief Nurse**	9.05am – 9.20am
5.2	**EMERGENCY FLOOR FULL BUSINESS CASE** *For approval*	**D**	**Chief Executive/ Director of Strategy**	9.20am – 9.30am
5.3	**EMERGENCY CARE PERFORMANCE REPORT** *For discussion*	**E**	**Chief Operating Officer**	9.30am – 9.40am
5.4	**UHL INITIAL DRAFT ANNUAL OPERATIONAL PLAN FOR 2015-16** *For approval*	**F (to follow)**	**Director of Strategy**	9.40am – 9.50am
6.	**GOVERNANCE**			

6.1	**MUTUALS IN HEALTH PATHFINDER UPDATE** *For discussion*	**G**	**Chief Executive**	9.50am – 9.55am
6.2	**WORKFORCE EQUALITY AND DIVERSITY MONITORING REPORT 2013-14** *For approval*	**H**	**Acting Director of Human Resources**	9.55am – 10.05am
6.3	**BOARD ASSURANCE FRAMEWORK** *For discussion*	**I**	**Deputy Chief Nurse**	10.05am – 10.15am
7.	**REPORTS FROM BOARD COMMITTEES**			
7.1	**QUALITY ASSURANCE COMMITTEE** Minutes of the 15 December 2014 meeting for noting and endorsement of any recommendations.	**J**	**QAC Chair**	10.15am – 10.20am
7.2	**FINANCE AND PERFORMANCE COMMITTEE** Minutes of the 18 December 2014 meeting for noting and endorsement of any recommendations.	**K**	**FPC Chair**	10.20am – 10.25am
8.	**TRUST BOARD BULLETIN – JANUARY 2015**	**L**	**-**	-
9.	**QUESTIONS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING**		**Chairman**	10.25am – 10.30am
10.	**ANY OTHER BUSINESS**		**Chairman**	10.30am – 10.35am
11.	**DATE OF NEXT MEETING**			
	The next Trust Board meeting will be held on Thursday 5 February 2015 from 9am in Seminar rooms A & B, Clinical Education Centre, Leicester General Hospital site.			
12.	**EXCLUSION OF THE PRESS AND PUBLIC** It is recommended that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded from the following items of business, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (items 13-17).			
Comfort break 5 minutes				
13.	**DECLARATIONS OF INTERESTS** Members of the Trust Board and other persons attending are asked to declare any interests they may have in the business on the agenda (Standing Order 7 refers). Unless the Trust Board agrees otherwise in the case of a non-prejudicial interest, the person concerned shall withdraw from the meeting room and play no part in the relevant discussion or decision.			
14.	**CONFIDENTIAL MINUTES** Confidential Minutes of the 22 December 2014 Trust Board meetings. *For approval*	**M**	**Chairman**	-
15.	**MATTERS ARISING**	**N**	**Chairman**	10.40am – 10.45am

	Confidential action log from the 22 December 2014 Trust Board. *For approval*			
16.	**REPORTS FROM BOARD COMMITTEES**			
16.1	**QUALITY ASSURANCE COMMITTEE** Confidential Minutes of the 15 December 2014 meeting for noting and endorsement of any recommendations. *Personal information*	**O**	**QAC Chair**	10.45am – 10.50am
16.2	**FINANCE AND PERFORMANCE COMMITTEE** Confidential Minutes of the 18 December 2014 meeting for noting and endorsement of any recommendations. *Commercial interests*	**P**	**FPC Chair**	10.50am – 10.55am
17.	**ANY OTHER BUSINESS**	**-**	**Chairman**	10.55am – 11am

Kate Rayns
Acting Senior Trust Administrator

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON MONDAY 22 DECEMBER 2014 AT 10AM IN SEMINAR ROOMS A & B, CLINICAL EDUCATION CENTRE, LEICESTER GENERAL HOSPITAL

Voting Members Present:
Mr K Singh – Trust Chairman
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Dr K Harris – Medical Director
Mr R Mitchell – Chief Operating Officer
Ms R Overfield – Chief Nurse
Mr P Panchal – Non-Executive Director
Mr M Traynor – Non-Executive Director
Mr P Traynor – Director of Finance
Mr M Williams – Non-Executive Director
Ms J Wilson – Non-Executive Director

In attendance:
Ms K Bradley – Director of Human Resources
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 326/14)
Mrs K Rayns – Acting Senior Trust Administrator
Ms K Shields – Director of Strategy
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications

ACTION

314/14 APOLOGIES

Apologies for absence were received from Mr J Adler, Chief Executive, Dr A Bentley, Leicester City CCG representative, and Professor D Wynford-Thomas, Non-Executive Director.

315/14 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

There were no declarations of interests relating to the public items being discussed.

316/14 MINUTES

Resolved – that the Minutes of the 27 November 2014 Trust Board (paper A) be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR**

317/14 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. In respect of item 1 (Minute 298/14 of 27 November 2014 refers), it was confirmed that an analysis of UHL's myNHS data (relating to Consultant level outcomes) would be circulated prior to the 8 January 2015 Trust Board meeting. **DS**

Resolved – that the update on outstanding matters arising and the timescales for resolution be noted.

318/14 CHAIRMAN'S UPDATE REPORT – DECEMBER 2014

The Chairman introduced paper C, highlighting the celebration of Christmas and the range

of other religious festivals which had been celebrated with equal depth, since he had taken up his role as UHL Chairman. He also outlined some of the external and internal factors affecting UHL's performance including relationships with other organisations, accountability arrangements, use of resources and long term sustainability, noting that quality improvement did not always require investment in additional resources.

Resolved – that the position be noted.

319/14 CHIEF EXECUTIVE'S MONTHLY UPDATE REPORT – DECEMBER 2014

In the absence of the Chief Executive, the Trust Chairman outlined the arrangements for Executive Directors to brief the Board on the key issues identified in paper D within their substantive reports which all featured later in the Trust Board agenda:-

(a) emergency care performance – Chief Operating Officer;
(b) RTT performance – Chief Operating Officer;
(c) month 8 financial position – Director of Finance;
(d) Better Care Together – Director of Strategy, and
(e) the Dalton Review: options for providers of NHS care – Director of Strategy.

Resolved – that briefings on the key issues outlined in the Chief Executive's monthly update report be provided under the substantive reports on the agenda.

320/14 KEY ISSUES FOR DECISION/DISCUSSION

320/14/1 Emergency Care Performance Report and Response to the Sturgess Report

The Chief Operating Officer introduced paper E, updating the Board on recent emergency care performance and providing copies of the Sturgess report, the related health economy response, the new system wide Operational Plan and a briefing on the new enhanced programme management arrangements across the system and within UHL.

The Trust Board noted the continued deterioration in performance against the 95% 4 hour ED target (November 2014 performance stood at 89.1%) as a result of high numbers of medical emergency admissions, lack of external capacity and internal processes failing during periods of high activity pressures. Within the last month, UHL had declared 5 internal major incidents. During a recent such incident on 9 December 2014, GPs from West Leicestershire CCG and East Leicestershire and Rutland CCG had provided welcome input to the incident response by supporting increases in discharge rates. These GPs had since provided positive feedback in terms of UHL's internal engagement in addressing the issues faced.

The Chief Operating Officer reported his heightened concerns regarding the impact of the increased activity upon the quality of care being provided to patients in terms of ambulance handover waiting times, high ED occupancy levels, long waits for bed availability, high numbers of patients on outlier wards and cancelled operations on and prior to the day of surgery. He also commented on the impact upon staff working under intense pressure for sustained periods of time. Assurance was provided that all internal actions were underway to reduce clinical risk (eg additional ward rounds for outliers, additional Consultant input at the weekends), and GP triage had been re-instated. All available inpatient bed capacity was currently open, which in turn, meant that staffing levels were being stretched.

In terms of the LLR health economy response to the current pressures on the emergency care system and the Sturgess report, there had been no evidence of the required changes in admission rates or discharge rates. Delayed transfers of care (DTOCs) remained high; as at 22 December 2014, there were 91 DTOCs declared and 71 of these were awaiting input from outside UHL. Confirmation was provided that the UHL actions to respond to the

Sturgess report (as set out in appendix 2) were being progressed at pace, but it was considered unlikely that the system would be able to accommodate the expected 11% rise in emergency admissions (forecast between January and March 2015), without the use of 67 community based beds which were currently closed.

The Chief Nurse provided her assessment of the additional clinical risk associated with the high levels of emergency activity, noting that it had recently become necessary to cancel surgery for some cancer patients and that a risk assessment was currently being undertaken to assess the likelihood of any patient harm arising from these cancellations. She also noted that Matrons' supervisory capacity had been removed in favour of protecting the minimum nurse staffing levels on wards.

The Medical Director noted the serious nature of the position for the whole health economy and commented upon the scope to share and mitigate clinical risks on a balanced system wide basis. He noted (for example) that the risks involved in delayed ambulance transfers preventing an ambulance from attending a serious road traffic collision were higher than the risks relating to the opening of community based rehabilitation beds to care for those patients whose episodes of acute care had been completed.

The Trust Chairman sought and received an update on the status of discussions with UHL's partner organisations regarding additional community based bed capacity and opportunities for an alternative management model for ward 2 on the LGH site (which accommodated patients with the lowest acuity). Following a detailed discussion on the reasons for Commissioners' apparent reluctance to re-open community bed capacity and the current mismatch between patient demand and bed capacity, the Trust Board endorsed the following key actions:-

(i)	the Trust Chairman to invite the 3 CCG Chairs and the LPT Chair to attend a risk summit (to be held on 23 December 2014) to progress an urgent local resolution to improve the current quality of care and patient experience for emergency and elective patients at UHL during this period of unprecedented demand;	**Chair**
(ii)	a formal letter to be sent to the Chairs of each organisation following the above risk summit, setting out the agreed actions and timescales in a clear and robust manner;	**Chair**
(iii)	a briefing on the outcomes of the above risk summit to be circulated to Trust Board members within the subsequent 48 or 72 hours, and	**Chair**
(iv)	monthly updates to be provided to the Trust Board on the LLR emergency care response, to include outcome based indicators and progress with implementation of the recommendations arising from the Sturgess report.	**COO**

<u>Resolved</u> – that (A) the update on emergency care performance and implementation of the recommendations arising from the Sturgess report be received and noted,

(B) the Trust Chairman be requested to undertake the actions outlined in points (i) to (iii) above, and **Chair**

(C) the Chief Operating Officer be requested to provide monthly emergency care updates to the Trust Board as detailed in point (iv) above. **COO**

320/14/2 <u>UHL 5 Year Plan Refresh</u>

The Director of Strategy presented paper G, providing an executive summary briefing on the refresh of UHL's 5 Year Integrated Business Plan in the light of recent national policy changes, internal operational changes and the development of the refocused UHL vision statement. She confirmed that a log of the key changes would be maintained through a version control mechanism and she highlighted the importance of a flexible approach to take account of future service changes.

Trust Board members noted that the timetable and milestones would be provided as separate appendices to the main Integrated Business Plan alongside the long term financial model, workforce plan and capital programme, which would be completed early in 2015. In response to a Non-Executive Director's query regarding the arrangements for public consultation, the Director of Strategy advised that the majority of consultation would be conducted through the Better Care Together Programme, although a separate report on the reconfiguration of intensive care services was due to be submitted to the Trust Board on 8 January 2015.

Resolved – that the key changes to the executive summary of UHL's 5 Year Integrated Business Plan be approved. **DS**

320/14/3 Delivering the 5 Year Strategy – Proposed Governance

Paper H briefed Trust Board members on the programme brief and proposed governance arrangements for UHL's reconfiguration programme in response to the requirements of the DoH Gateway Zero review carried out in October 2014.

Resolved – that (A) the programme brief and proposed governance arrangements for delivering UHL's 5 Year Strategy be endorsed, and **DS**

(B) the Director of Strategy be requested to provide regular progress reports to the Trust Board on delivering the 5 Year Strategy. **DS**

320/14/4 Better Care Together Programme – Strategic Outline Case and Project Initiation Document

Further to Minute 311/14 of 27 November 2014, the Director of Strategy introduced paper I, seeking Trust Board approval of the Better Care Together SOC and implementation plan (as developed by the Better Care Together Partnership Board) for onward submission to the NTDA and the DoH.

Resolved – that (A) the Better Care Together Programme SOC and PID be approved, and

(B) the Chief Executive be authorised to pursue the key actions (as set out in paper I) in conjunction with LLR health and social care partners. **CE**

321/14 QUALITY AND PERFORMANCE

321/14/1 Month 8 Quality and Performance Report

Due to the earlier than usual timing of the Quality Assurance Committee and Finance and Performance Committee meetings within the month of December 2014, the month 8 Quality and Performance report (paper J – month ending 30 November 2014) had been submitted directly to the Trust Board. Paper J highlighted the Trust's performance against key internal and NTDA metrics, with escalation reports appended where required.

In terms of the 15 December 2014 QAC meeting, Dr S Dauncey, Non-Executive Director and Acting QAC Chair, highlighted the following issues:-

(i) the arrangements for developing a business case for the supply of medicines via homecare schemes, and
(ii) significant progress being made with safeguarding training and awareness and the triangulation of patient experience feedback.

In addition, the Chief Nurse highlighted concerns relating to incidences of avoidable grade 2 pressure ulcer damage (as summarised in the associated exception report provided on page

12), noting that awareness of such damage was improving, eg damage to a patient's face or ears caused by oxygen tubing. She also commented on the impact of high activity levels upon the internal stretch target for Clostridium Difficile infections, noting that the Trust's ability to provide decant accommodation for steam cleaning wards was currently compromised. The Medical Director advised that fractured neck of femur performance continued to cause a concern as highlighted in the exception report provided on page13 of paper J.

Ms J Wilson, Non-Executive Director and Finance and Performance Committee Chair then outlined key financial and operational issues discussed by the 18 December 2014 Finance and Performance Committee, namely:-

(a) key operational performance issues (including ED performance, cancer performance and admitted RTT performance);
(b) financial performance for month 8 and the 2014-15 financial year to date;
(c) draft financial planning guidance for 2015-16 which was still subject to formal consultation, but particular concern was noted in respect of the draft tariff for commissioning of specialised services, and
(d) consideration of the full business case for the Emergency Floor which was due to be presented to the Trust Board on 8 January 2015 for approval.

The Chief Operating Officer summarised the Trust's position in respect of RTT performance, cancer performance, cancelled operations and ambulance handovers, noting that a significant reduction in the number of 30 and 60 minute ambulance breaches was expected to be evidenced from January 2015 onwards (once the Trust's data collection mechanism was converted to RFID tagging). Admitted RTT performance had been improving steadily and the final plan to achieve compliant performance was currently being validated prior to submission to the NTDA. Compliance with the cancer targets was expected to be achieved in December 2014 for 2 week waits, January 2015 for 31 day targets and February 2015 for the 62 day targets.

The Director of Human Resources confirmed that any workforce issues of note, were summarised in the quarterly update on Organisational Development (paper L refers).

The Minutes of the 26 November 2014 Finance and Performance Committee and Quality Assurance Committee meetings were received and noted as papers J1 and J2 (respectively).

Resolved – that the month 8 quality and performance report for the period ending 30 November 2014 (paper J) be received and noted.

321/14/2 Month 8 Financial Position

The Director of Finance presented paper K advising members of UHL's financial position as at month 8 (month ending 30 November 2014), particularly highlighting performance against the Trust's statutory financial duties and the following key issues:-

(a) a positive in-month variance to plan of £0.3m, and a year to date deficit against plan of £1.4m;
(b) strong performance against the Trust's 2014-15 Cost Improvement Programme (CIP) and good progress with the development of CIP plans for 2015-16;
(c) continued challenges for the Clinical Management Groups to deliver their year-end control totals in the context of winter pressures;
(d) expected changes to the risk profile (as set out in section 7 of the report) for the next iteration of this report;
(e) progress with contractual discussions which were expected to be finalised before or soon after Christmas 2014 – the quantum of the potential margin had reduced

significantly which had de-risked the year end position to some extent, and

(f) the 23 December 2014 deadline for consultation in response to the draft Tariff Guidance, noting the welcome impact of changes to the marginal rate emergency tariff (MRET) and the risks surrounding the proposals for specialised commissioning.

In discussion on the month 8 financial performance update, the Trust Board:-

(i) received additional information provided by the Director of Strategy in respect of the proposed risk sharing arrangements for specialised commissioning procurement costs (eg chemotherapy drugs, specialised medical devices and prosthetics) whereby UHL would only be reimbursed for 50% of any costs over the agreed baseline threshold, and

(ii) considered the impact of the potential introduction of Commissioner-led penalties for non-compliance with the 4 hour ED target.

Resolved – that the month 8 financial performance update be noted.

322/14 WORKFORCE

322/14/1 Quarterly Update on Workforce and Organisational Development

The Director of Human Resources introduced paper L, highlighting progress with implementation of the Trust's Organisational Development Plan and setting out progress with the creation of an Organisational Health Dashboard. She particularly drew members' attention to the Accountability into Action Development Programme which aimed to increase the focus on holding effective conversations within the performance management culture and holding individuals to account in a positive way. A presentation would be provided to the 23 December 2014 Executive Workforce Board together with proposals for some initial pilot activity.

Appendix 2b on page 11 of paper L provided the October 2014 Organisation Health Dashboard, summarising CMG-level performance against a range of key workforce indicators. Discussion took place regarding positive movements in statutory and mandatory training compliance (87%) and appraisals (93%). In response to a Non-Executive Director query, the Director of Human Resources agreed to re-confirm the interpretation of the arrow indicators, noting that an upwards arrow might not always indicate a positive improvement, for example if sickness absence rates increased, then this would reflect a deterioration in performance.

In discussion on paper L, the Non-Executive Director Finance and Performance Committee Chair commented upon the intention to embed performance and workforce dashboards within the CMG presentations to the Integrated Finance, Performance and Investment Committee during 2015. She also noted the scope for Grahame Rob Associates to influence the Trust Board development programme as part of the Accountability into Action workstream. Finally, Mr M Traynor, Non-Executive Director commended a recent Apprentice Showcase event and the Director of Human Resources echoed this view, confirming that UHL now had approximately 140 apprentices and that the video clips provided at that event had demonstrated the depth and breadth of UHL's Apprentice Programme.

Resolved – that the quarterly update on Workforce and Organisational Development be received and noted.

323/14 RESEARCH AND DEVELOPMENT

323/14/1 Quarterly Update on Research and Development Issues

The Medical Director introduced the quarterly update on research and development at UHL (paper M refers) and particularly noted the following key developments:-

(a) quarter 2 compliance with the national target for recruiting the first patient into initiated trials within 70 days from submission and the work ongoing to sustain this performance to retain 100% of the research capability funding for 2015-16;
(b) UHL's role as one of the host organisations for the Life Study in partnership with University College London, and
(c) UHL's participation in the 100,000 Genome Project in partnership with Cambridge University Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust, and Nottingham University Hospitals NHS Trust.

Finally, section 6 of paper M sought Trust Board approval to re-name the Research and Development Office as the Research and Innovation Office, to take account of the role in supporting innovation throughout the Trust and to be consistent with the naming of this function within other NHS Trusts. Subject to the Board's approval, it was also proposed to launch a new website to support this change and refresh UHL's Research and Innovation profile.

Resolved – that (A) the quarterly update on research and development issues be received and noted, and

(B) the re-naming of the Research and Development Office at UHL as the Research and Innovation Office be approved. **MD**

324/14 GOVERNANCE

324/14/1 Duty of Candour/Fit and Proper Persons Test

The Director of Corporate and Legal Affairs introduced paper N, providing a briefing on the implementation of new health and social care standards and specifically the fit and proper persons requirements and duty of candour which became effective from 27 November 2014. He advised that the Chief Nurse would be providing a further report on the arrangements for meeting the requirements of duty of candour to the Quality Assurance Committee on 29 January 2015. In addition, the Director of Human Resources would be reporting on the arrangements for meeting the requirements of the fit and proper person test to the Trust Board on 5 February 2015. **CN** **DHR**

In discussion on the report, Trust Board members noted the expected cultural changes for NHS Trust Boards, the provision of CQC interim guidance, the scope for increased penalties for non-compliance with these new standards, and the arrangements for increasing the level of transparency within the Trust Board agenda, confirming that all items would feature on the public agenda unless there were any commercial exemptions or any personal data was included.

Resolved – that (A) the briefing on implementation of new health and social care standards be received and noted as paper N;

(B) the Chief Nurse be requested to report on the arrangements for meeting the requirements of the duty of candour at the 29 January 2015 QAC meeting, and **CN**

(C) the Director of Human Resources be requested to report on the arrangements for meeting the requirements of the fit and proper persons test at the 5 February 2015 Trust Board meeting. **DHR**

324/14/2 Board and Board Committee Governance

The Director of Corporate and Legal Affairs introduced paper O, seeking Trust Board approval of the proposed Committee structure and membership/attendance at Board Committees, as set out in appendices A and B (respectively) and noting the ongoing work with Board Intelligence to improve the quality of Trust Board reports going forwards.

In discussion on the report, the Trust Chairman sought and received additional information regarding the existing arrangements for joint CCG representation at UHL's Trust Board and QAC meetings and commented upon opportunities to include CCG Non-Executive Director or Lay Member representation (where appropriate). He undertook to write to the CCG Chairs to consult their views on this matter and invite appropriate nominations.

In addition to the UHL core membership of Board Committees (as set out in appendix B), clarity was provided that all UHL Non-Executive Directors were encouraged to attend all Board Committee meetings, and that any non-voting Director members would be recorded as being "in attendance" rather than "present" within the Minutes of each meeting.

Resolved – that (A) the proposed Committee structure and membership/attendance at Board Committees be approved, and **DCLA**

(B) the Trust Chairman be requested to write to the CCG Chairs consulting them on the arrangements for joint CCG representation and inviting appropriate nominations. **Chair**

324/14/3 NHS Trust Over-Sight Self Certification

The Director of Corporate and Legal Affairs introduced the Trust's over-sight self certification return for November 2014 (paper P refers). Following due consideration, and taking appropriate account of any further information needing to be included from today's discussions (including the month 8 exception reports, as appropriate), the Board authorised the Director of Corporate and Legal Affairs to finalise and submit the December return to the NHS Trust Development Authority in consultation with the Chief Executive. **DCLA/ CE**

Resolved – that (A) paper P, now submitted, be received and noted,

(B) the Director of Corporate and Legal Affairs be authorised to agree a form of words with the Chief Executive in respect of the NHS Trust Over-sight self certification statements to be submitted to the NHS Trust Development Authority by 31 December 2014. **DCLA/ CE**

325/14 TRUST BOARD BULLETIN

Resolved – that no bulletin items were circulated for December 2014.

326/14 QUESTIONS AND COMMENTS FROM THE PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

A patient commented that the informative nature of the discussion on UHL's emergency care performance had been welcome.

Resolved – that the questions and related responses, noted above, be recorded in the Minutes.

327/14 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 328/14 – 33414), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public

interest.

328/14 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

There were no declarations of interest in the confidential business being discussed.

329/14 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 27 November 2014 Trust Board be confirmed as a correct record and signed accordingly by the Trust Chairman. **CHAIR**

330/14 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

331/14 REPORTS BY THE DIRECTOR OF FINANCE

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

332/14 REPORTS FROM BOARD COMMITTEES

332/14/1 Finance and Performance Committee

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

332/14/2 Quality Assurance Committee (QAC)

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information.

333/14 ANY OTHER BUSINESS

333/14/1 Ms K Bradley – Director of Human Resources

Noting that this would be Ms Bradley's last UHL Trust Board meeting before she left the Trust on 23 December 2014, the Trust Chairman thanked her for her contribution to the Trust and wished her well in her new post with the University of Leicester.

Resolved – that the position be noted.

333/14/2 Report by the Chief Nurse

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal information.

334/14 DATE OF NEXT MEETING

Resolved – that the next Trust Board meeting be held on Thursday 8 January 2015 from 9am in the C J Bond room, Clinical Education Centre, Leicester Royal Infirmary.

The meeting closed at 1.05pm

Kate Rayns
Acting Senior Trust Administrator

Cumulative Record of Attendance (2014-15 to date):

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh (Chair from 1.10.14)	3	3	100	R Mitchell	10	9	90
R Kilner (Acting Chair from 26.9.13 to 30.9.14)	7	7	100	R Overfield	10	10	100
J Adler	10	9	90	P Panchal	10	10	100
T Bentley*	9	7	78	K Shields*	10	10	100
K Bradley*	9	9	100	M Traynor (from 1.10.14)	3	3	100
I Crowe	10	9	90	P Traynor (from 27.11.14)	2	2	100
S Dauncey	10	9	90	S Ward*	10	10	100
K Harris	10	9	90	M Wightman*	10	10	100
D Henson*	6	6	100	M Williams	3	3	100
K Jenkins (until 30.6.14)	3	3	100	J Wilson	10	8	80
				D Wynford-Thomas	10	4	40

* non-voting members

University Hospitals of Leicester NHS Trust

Progress of actions arising from the Trust Board meeting held on Monday, 22 December 2014

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
1	320/14/1 (a)	***Emergency Care Performance Report and Response to the Sturgess Report*** Trust Chairman to convene a risk summit with local health economy partners on 24 December 2014 to progress an urgent local resolution to improve the quality of patient care and patient experience during the current period of unprecedented demand.	Chair	Immediate	Complete.	5
2	320/14/1 (b)	Formal letter to be sent to the Chairs of local health economy partners confirming the outputs of the risk summit and a copy of this letter to be circulated to Board members within 72 hours.	Chair	26.12.14	Complete.	5
3	320/14/1 (c)	Chief Operating Officer to provide monthly emergency care reports to the Trust Board to include outcome based indicators and progress with the implementation of the recommendations arising from the Sturgess report.	COO	8.1.15	Report provided for 8 January 2015 and monthly reports scheduled on the Trust Board agenda.	5
4	320/14/3	***Delivering the 5 Year Strategy*** Director of Strategy to provide regular progress reports to the Trust Board on delivering the 5 Year Strategy.	DS	TBA	Reports to be scheduled on the Board agenda. Frequency to be agreed in consultation with the Director of Strategy.	4
5	324/14/1 (a)	***Duty of Candour/Fit and Proper Persons Test*** Chief Nurse to report on the arrangements for meeting the requirements of the duty of candour at the 29 January 2015 QAC meeting.	CN	QAC 29.1.15	Report provisionally scheduled on the 29 January 2015 QAC agenda.	4
6	324/14/1 (b)	Acting Director of Human Resources to report on the arrangements for meeting the requirements of the fit and proper persons test at the 5 February 2015 Trust Board meeting.	DHR	TB 5.1.15	Report provisionally scheduled on the 5 February 2015 Trust Board agenda.	4
7	324/14/2	***Board and Board Committee Governance*** Trust Chairman to write to the CCG Chairs consulting them on the arrangements for joint CCG representation on UHL Board Committees and inviting appropriate nominations.	Chair	TBA	Actioned – response of CCG Chairs awaited.	4

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
8	324/14/3	***NHS Trust Over-Sight Certification*** Director of Corporate and Legal Affairs and the Chief Executive to update the November 2014 self certification returns using the month 8 quality and performance exception reports and submit these to the NTDA by 31 December 2014.	DCLA/CE	31.12.14	Complete.	5

Matters arising from previous Trust Board meetings

Item No	Minute Ref:	Action	Lead	By When	Progress Update	RAG status*
27 November 2014						
9	298/14	***Chief Executive's monthly report*** An analysis of the Trust's MyNHS data (relating to Consultant level outcomes) to be circulated to Trust Board members outside the meeting.	DS	TB 8.1.15	Work in progress.	4

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Agenda Item: Trust Board Paper C

TRUST BOARD – 8 JANUARY 2015

Patient Experience Story – Care and Attention Beyond Expectation

DIRECTOR:	Rachel Overfield, Chief Nurse
AUTHOR:	Clair Rix, Ward Sister Amy Lynds, Deputy Sister
DATE:	8th January 2015
PURPOSE:	Introduction To describe the excellent experience of care a patient received when attending for planned surgery at the Leicester General. Also how services are continually being changed in response to patient feedback. Ward 14 would like to share this positive experience of care with Trust Board and use it to illustrate their on-going commitment and drive to improve care delivery leading to patient led services. Ward 14 Friends & Family Test In November 2014 the Friends and Family Test for ward 14 was: **Promoters** 25 | **Passives** 5 | **Detractors** 1 | **FFT Score** **77.4** Patient's Experience of Care This patient story identifies: • The excellent care and support offered which started at the beginning of a planned surgical journey; from Orthopaedic Pre-Assessment Clinic which was incredibly well managed through to discharge from the compassionate care and attention of the ward post operatively • How all members of staff have carried out their duties both professionally and with a smile which made the stay in hospital considerably less stressful than previously expected. This attitude was experienced from everyone; including consultants, nurses, anaesthetists, and physiotherapists, occupational therapists, catering and cleaning staff. Changing Practise in line with Patient Feedback In November 2013, Ward 14 had a Friends and Family Test score of 46.2. All clinical areas with a Friends and Family Test below 55 are provided with additional support and patient feedback surveys, comments and complaints are examined in detail to elicit the 'root cause' from a patient's perception of this experience of care. The team identified a number of areas that from the patients perception needed improving:

	Care and Compassion while in hospital 1. Increased Health Care Assistants now meets acuity for the ward 2. The Ward Sister has worked with the staff to improve how welcoming and friendly staff are on the ward by sharing positive feedback and directly addressing poor attitude 3. Comments from feedback made regarding an individual's behaviour or attitude is managed immediately highlighting expectations required from this ward 4. Increasing staff awareness around care and compassion is addressed through staff meetings and the monthly newsletter reinforcing positive patient experience. This has led to improvement in the scores for the question "While in hospital did you feel you were treated with care and compassion?" (November 2013 score 93, November 2014 score 98). The ward team demonstrates delivery of care with sensitivity, respecting patient's choices and decisions, effectively communicating with compassion and treating patients with dignity and respect. **Improving communication and availability of staff** 1. To increase effective communication the freshly introduced named nurse board above the bed of each patient is changed at the beginning of each shift, ensuring that each patient knows which nurse is looking after them 2. Patient perception was that the team often talked over them as if they were not there; the team are working towards ensuring all patients are involved in their care and treated with dignity and respect 3. The ward ensures that all information on patient information boards is up to date; including Friends and Family Test scores, patient experience feedback and patient education information and leaflets 4. A team training day has been booked in January 2015 to support ongoing improvements towards effective communication and positive patient experience. **Need 'entertainment' to help pass the time** 1. Televisions were donated to the ward for the four bays and day room to provide entertainment by a previous patient whom wanted to thank the ward team following the care they received 2. Patient feedback has recently identified that more radios are required and these along with televisions for the side rooms will be purchased following this year's Christmas raffle. <u>Future Improvements</u> To continue to offer a service of excellence based on the needs of patients with on-going appraisal of patient feedback. <u>Recommendations:</u> The Trust Board is asked to: • Receive and listen to the patient's story
PREVIOUSLY CONSIDERED BY:	None
Objective(s) to which issue relates *	[Y] 1. Safe, high quality, patient-centred healthcare [ ] 2. An effective, joined up emergency care system [Y] 3. Responsive services which people choose to use (secondary, specialised and tertiary care)

	☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	This paper provides assurance that ward 14 and the wider multi-disciplinary team are listening and acting upon patient feedback to improve patient's experience of care. Patients are encouraged to share their stories of care within the Trust.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	An equality impact assessment was not required in relation to this patient story.
Strategic Risk Register/ Board Assurance Framework *	☐ **Strategic Risk Register** ☐ **Board Assurance Framework** ☒ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☒ For information ☒

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper D

Emergency Floor Full Business Case (FBC)

DIRECTOR:	**John Adler, Chief Executive and Kate Shields, Director of Strategy**
AUTHOR:	**Nicky Topham, Project Director**
DATE:	**Trust Board 8th January 2015**
PURPOSE:	To brief the Trust Board on the critical issues relating to the successful delivery of the Emergency Floor Full Business Case (FBC). To request Trust Board approve the FBC, following which it will be submitted to the NHS Trust Development Authority (NTDA).
PREVIOUSLY CONSIDERED BY:	Finance & Performance Committee – 18th December 2014 Emergency Floor Project Board - 15th December 2014 Developed OBC Approved by Trust Board – August 2014
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [ ] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [ ] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [ ] 5. Enhanced reputation in research, innovation and clinical education [ ] 6. Delivering services through a caring, professional, passionate and valued workforce [ ] 7. A clinically and financially sustainable NHS Foundation Trust [ ] 8. Enabled by excellent IM&T

Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Full patient and stakeholder engagement has been incorporated in the design process: • Geriatric and Adolescent Design groups were set up to involve representatives from the Trust's public and patient involvement groups to provide input into the design; from the layout of rooms within an area to suggestions of decoration, equipment and items to improve patient experience. These design groups also involved representatives from charities such as AgeUK and VistaBlind, as well as a research team from Loughborough University who recently received a £50m grant from the Department of Health in order to carry out pilot schemes to trial improvements to geriatric environments within the acute care setting. The project's Gateway 2 Report identified these efforts as an example of best practice.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	A due regard assessment has been undertaken which indicates that no group will be disadvantaged by the scheme.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☒ For assurance ☐ For information ☐

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♦ We are passionate and creative in our work

BACKGROUND

1. The "developed" Outlined Business Case (OBC) was approved by the Trust Board in August 2014 and then submitted to the NHS Trust Development Authority (NTDA) .

2. The NTDA responded with a number of queries to the OBC regarding the finance models and clarifications which have now been incorporated into the Full Business Case (FBC).

3. The Regional Office of the NTDA has completed its scrutiny of the OBC and will be making a recommendation to the National Capital Investment Group to approve the OBC on January 15th 2015.

4. This FBC is consistent with the "developed" OBC in terms of workforce, activity and finance assumptions.

5. The FBC was scrutinised and supported by the Project Board on December 15th 2014.

6. The FBC was scrutinised and supported by the Finance and Performance committee on the 18th December 2014, subject to a clear statement in the FBC that describes the contingency plans if future activity is not as currently projected by the Better Care Together Programme.

ISSUES RAISED BY THE FINANCE &PERFORMANCE COMMITTEE

7. **The approach to VAT recovery**: The VAT recovery assessment is calculated on a percentage basis. In order to be assertive on VAT recovery the Trust has engaged a recognised VAT Consultant from the Heart of England NHS Trust who will review the project in detail to provide VAT certainty and target the upper bounds of VAT recovery.

8. **Chair of the Project Board:** The Project Board is currently chaired by the Medical Director, Kevin Harris, who will be stepping down from the role in April 2015. The Chief Executive will appoint an alternative suitable Chair to take over this role.

9. **The level of inflation was challenged:** The OBC included inflation which was based on industry standard presentation of inflation at OBC stage. The FBC includes market tested costs which reflect a fixed price for construction. The risk of inflation sits with our construction delivery partner Interserve Construction Ltd.

10. **Flexibility around design if future growth surpasses that modelled in the FBC Better Care Together scenario (the impact of which might not manifest itself for 10-15 years):** The design delivers a solution that is flexible in functionality and can provide capacity for current demand whilst enabling realisation of the 20 year capacity requirement:

- Within the Emergency Department, the Minor Illness and Minor Injury Unit is a combined and totally flexible area for the urgent care centre.
- Majors is designed in two sections, so that in the event that flows are blocked, half of Majors can flex into an assessment area. The assessment areas are designed as generic beds
- The development control plan (DCP) for the LRI site takes account of the emergency floor and future development of the site.
- The structural design of the emergency floor has been developed to accommodate an additional floor at a later stage, in line with the Trust's DCP.

11. Contingency from an operational perspective will be provided by:

- A clear focus in UHL on bed utilisation and flow through the internal UHL system. This work will target admission, discharge and avoidance of admissions where out of hospital care is preferable.
- Relocation of the UCC and minors to an alternative location would free-up capacity within the proposed design for higher acuity workload

ISSUES AND RISKS

Risks

12. **Timescales:** the NTDA are due to approve the OBC on the 15th January 2015. If the National Capital Investment group do not support the OBC on 15th January, the Trust Board approval of the FBC may be negated.

13. **Purdah:** the period of purdah prior to the General Election starts on March 20th 2015. If the FBC does not get approved by the NTDA at their Board on the 19th March 2015, the project will be on hold for at least 6 months which would have an impact on project costs due to inflation. A change of government could affect the NHS investment strategy.

15 Dec 14	FBC approved by Project Board for onward submission to F&P
18 Dec 14	FBC approved by F&P Committee for onward submission to Trust Board
8 Jan 15	FBC due to be approved by Trust Board
9 Jan 15	FBC due to be issued to NTDA
15 Jan 15	**OBC to NTDA National Capital Investment Group – Supported by the Regional Office**
15 Jan – 19 Mar 15	NDTA Queries addressed – Possible Addendum – Further Trust Board Approval
20 Mar 15	**FBC to NTDA National Capital Investment Group**
21 Mar – 8 May 15	Purdah pending General Election

14. **Assumptions underpinning the FBC:** The FBC assumes activity and expenditure at forecast outturn for 2014/15. Any changes in this baseline will have an impact both operationally and financially. The design of the Emergency Floor will help to mitigate this change, as it is flexible and can accommodate both increases and decreases in activity levels.

15. The Trust does not have an alternative scheme if this scheme is not approved by the NTDA.

Issues still to be resolved

16. **Design of the assessment areas (Phase 2 of construction)**
The design of the assessment areas has progressed and will be developed from an Operational Policy to deliver a value for money solution from existing space that responds to efficient staffing models and utilisation of existing function space e.g. Emergency Decisions Unit.

17. **Compliance with Department of Health Building Notes (HBNs)**
Some room sizes are not HBN compliant and derogations have been included in the FBC. The NTDA have asked for independent verification of our rationale and derogations. An external ergonomics specialist has now undertaken this assessment, and advised that there are 2 specific room types that need to be reviewed to ensure operational functionality in a safe environment. These are the initial streaming rooms, and the assisted toilet / shower rooms. The design will be reviewed in January; the impact is not deemed to be material.

SUMMARY OF THE FBC

Design

18. The project comprises a new build Emergency Department and refurbishment of the space vacated by the existing emergency department, to create a new medical assessment unit. The overall project will be delivered in the following phases:

- **Service Isolation / Diversion and Demolition:** part of the existing Victoria Building will be demolished to make way for the new build phase 1.
- **Phase 1 New Build ED Construction**: construction of the new emergency department
- **Phase 2 Assessment and Refurbishment**: once the emergency department has moved from its existing location to the new build construction will commence to refurbish the existing space to create the medical assessment and geriatric units.

Activity

19. At the time of writing the OBC (August 2014), the Trust's Long Term Financial Model (LTFM) was not aligned to the Better Care Together planning assumptions, therefore there was a need to include two activity scenarios.

20. The commissioners have agreed a single activity model for the FBC which uses the forecast outturn activity for 2014/15 as the baseline; then applies the Better care Activity Assumptions over the subsequent 5 years using 2015/16 as year 1.

21. Within the first five years, activity levels are predicted to fall based on the assumption of implementation of Better Care Together Plans diverting attendances from ED to alternative providers of care in both primary and community settings. It is anticipated that after this point there will be a small increase in activity driven by changes in demographics and acuity levels.

22. This initial decrease in activity will impact on staffing and non-pay costs. Shifts in activity by type have been modelled and will be used to calculate the most appropriate staffing levels taking into the lead in times for education and training.

Finance

23. The capital costs of the preferred option total £43.3M including forecast out-turn inflation. Below is an analysis of the total costs.

Capital Costs	Option 3A Victoria (£)
Construction	32,489,899
Fees	5,614,257
Non Works Costs	76,021
Equipment	2,403,206
Planning Contingency	2,495,893
Sub Total	43,079,276
Optimism Bias	(Included in construction cost of GMP)
Inflation	924,489
Total	44,003,765
VAT Recovery	-674,738
Grand Total	**43,329,027**

24. The case shows that the Trust has clearly identified the capital requirements and has also identified relevant sources of funding.

Workforce

25. Key to delivery within financial balance is the development of an appropriate workforce to support activity levels within the new Emergency Floor. A detailed

workforce plan describes the overarching process for determining the proposed revenue cost reduction and includes details of both financial and non-financial benefits arising from the development of the emergency floor. The plan also includes potential risks and actions to mitigate these.

Outstanding Actions

26. The CCGs will be asked to write a letter of support for the FBC. We do not expect this to differ from the letter of support for the OBC.

27. The NTDA require that a Gateway 3 review of the FBC and a Design Quality Indicator Assessment of the design will be carried out before the final recommendation report is prepared. Both reviews are being set up for January, the outcomes of which will be forwarded to the NTDA.

    - N.B. Gateway: the project received an AMBER rating at Level 2. All outstanding actions for Gateway 2 have been completed. The importance of obtaining a GREEN rating was emphasised by the Finance &Performance Committee at the Level 3 Gateway review due to be undertaken in January 2015. If an AMBER or AMBER/GREEN rating is given, the Trust will need to be able to articulate and give confidence to the NTDA that any recommendations can be met

SUMMARY

28. In developing the FBC, efficiencies have been identified which demonstrates the case is affordable to the Trust. The efficiencies have been developed through detailed activity, capacity and workforce planning.

29. The Full Business Case is supported by the Finance & Performance Committee.

30. The FBC aligns with the Better care Together Programme and reflects an agreed activity model.

31. Derogations from HBN have been risk assessed and the design will be revised for these room types

32. Design development of Phase 2 is progressing in line with the budget and project timeline to deliver a clinical environment that responds to the operational policy

RECOMMENDATIONS

33. The Trust Board is asked to approve this Full Business Case for onward submission to the NTDA.

University Hospitals of Leicester NHS
NHS Trust

property and infrastructure | health

Full Business Case

Emergency Floor

December 2014

Version FINAL 1.7

Issue date 22nd December 2014

In Partnership with CAPITA Interserve

Document Quality Management

Title	FBC Emergency Floor
Date	22nd December 2014
Prepared by	Anna Fawcett, Assistant Consultant, Capita
Checked by	Chris Turner, Director, Capita
Authorised by	Nicky Topham, Project Director, University Hospitals of Leicester NHS Trust

Document History

Version	Date Issued	Brief Summary of Change	Author
1.0	19/11/2014	First draft	A. Fawcett
1.1	24/11/2014	Incorporation of narrative for Commercial, Equipping & Workforce sections.	A. Fawcett
1.2	02/12/2014	Incorporation of narrative for Strategic sections. Updates to Glossary of Terms.	A. Fawcett
1.3	08/12/2014	Incorporation of narrative for Financial & Economic sections. Small amendments throughout following full read through.	A. Fawcett N. Topham
1.4	09/12/2014	Inclusion of narrative for GMP, routes to affordability. Proof read, formatting, updates to figure/ table numbers and appendix references. Issued to Project Team for review and signoff.	A. Fawcett N. Topham
1.5	11/12/2014	Inclusion of amendments following Project Team review. Issued to Project Board & Director of Strategy for review and signoff.	A. Fawcett N. Topham
1.6	16/12/2014	Inclusion of amendments following Project Board review. Issued to F&P Committee for review and signoff.	A. Fawcett N. Topham
1.7	22/12/2014	Inclusion of amendments following F&P Committee review. Issued to Trust Board for signoff.	A. Fawcett N. Topham

Glossary of Terms

Abbreviation	Full Heading
ACB	Acute Care Bay
AFU	Acute Frailty Unit
ALOS	Average Length of Stay
BCT	Better Care Together
BREEAM	Building Research Establishment Environmental Assessment
CAP	Conservation Advisory Panel
CAU	Children's Assessment Unit
CCG	Clinical Commissioning Group
CDM	Construction, Design Management
CEM	College of Emergency Medicine
CGA	Comprehensive Geriatric Assessment
CHP	Combined Heat & Power
CMG	Clinical Management Group
CT	Computerised Tomography
DCP	Development Control Plan
DH	Department of Health
DQI	Design Quality Indicator
ECIST	Emergency Care Intensive Support Team
ECN	Emergency Care Network
ED	Emergency Department
EDU	Emergency Decisions Unit
EF	Emergency Floor
EFU	Emergency Frailty Unit
EMAS	East Midlands Ambulance Service

Abbreviation	Full Heading
EPR	Electronic Patient Record
FBC	Full Business Case
FOT	Forecast Outturn
FM	Facilities Management
GEM	Generic Economic Model
GMP	Guaranteed Maximum Price
HBN	Health Building Note
HTM	Health Technical Memorandum
GP	General Practitioner
HDU	High Dependency Unit
I&E	Income and Expenditure
IBP	Integrated Business Plan
IM&T	Information Management & Technology
IPR	Integrated Performance Report
ITU	Intensive Therapy Unit
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LCC	Leicester City Council
LLR	Leicester, Leicestershire & Rutland
LOS	Length of Stay
LPT	Leicestershire Partnership Trust
LRI	Leicester Royal Infirmary
LTFM	Long Term Financial Model
MES	Managed Equipment Service
MIaMIEE	Minor Injury and Minor Illness, Eyes, ENT
MRI	Magnetic Resonance Imaging

Abbreviation	Full Heading
MSK	Musculoskeletal
NEL	Non-elective
NIHR	National Institute of Health Research
NSF	National Service Framework
NTDA	NHS Trust Development Authority
OBC	Outline Business Case
OJEU	Official Journal of the European Union
ONS	Office of National Statistics
OSC	Overview Scrutiny Committee
PIR	Post Implementation Review
PPE	Post Project Evaluation
PSCP	Principal Supply Chain Partner
PUBSEC.BISFP	Public Sector, Dept. for Business Innovation & Skills Firm Price (Tender Price Index of Public Sector Buildings (Non-housing)
QIPP	Quality, Innovation, Productivity and Prevention
RAU	Rapid Assessment Unit
SDM	Senior Decision Maker
SI	Site Investigation
SOC	Strategic Outline Case
SSPAU	Short Stay Paediatric Assessment Unit
UCC	Urgent Care Centre
UHL	University Hospital of Leicester NHS Trust
VFM	Value For Money
YTD	Year To Date

Contents

Figures and Tables

1 | Executive Summary

1.1 Introduction

This Full Business Case (FBC) is for the redevelopment of the Emergency Department (ED), creating a new Emergency Floor (EF) on the Leicester Royal Infirmary site of University Hospitals of Leicester NHS Trust (hereafter referred to as 'UHL' or 'the Trust'). It proposes to develop an Emergency Floor that will address the demand challenges faced by both ED and medical assessment services, with the intention of developing a future proofed solution that will flexibly meet future demand over the next 20 years.

The Trust is one of the largest teaching Trusts in the country and operates across three main sites; Leicester Royal Infirmary, Leicester General Hospital and the Glenfield Hospital, and is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents.

Glenfield Hospital | Leicester General Hospital | Leicester Royal Infirmary

Figure 1.A University Hospitals of Leicester NHS Trust Sites

Leicester Royal Infirmary provides Leicestershire's only Emergency Department (ED), as well as being the base for the Trust's Children's Hospital and Urgent Care Centre (UCC).

In 2012 the Trust identified a number of services requiring redevelopment/ development across their three sites to ensure ongoing enhancement and maintenance of essential health services to the local community. As a consequence, the Trust has updated its 5 year estates strategy to provide an integrated and strategic approach to developing its estate and infrastructure; aligned to and reflecting the Clinical Strategy and Integrated Business Plan, and is consistent with the LLR system wide strategic plans.

This business case focuses on the Emergency Floor Reconfiguration project; the first of the main reconfiguration projects for the Trust. It highlights that current arrangements do not meet the current activity demands or the projected requirements over the next 20 years.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its Emergency Department (ED). This has resulted in many patients waiting for excessive periods and performance being well below the national standard of 95%; this reflects poor quality of care for patients, reduced clinical effectiveness, an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

In partnership with local commissioners, UHL has instigated a number of short term measures to improve performance, such as the addition of adult medical assessment beds and a new GP assessment clinic to alleviate current pressures. UHL has set out a clear vision for the future of the emergency care pathway and is undertaking a programme of change to redesign processes within the existing footprint and built environment, but there is still an issue with the design and size of the current ED and associated medical assessment areas in their entirety. They are deemed totally inadequate to cope with demand, as previously stated by the Emergency Care Intensive Support Team (ECIST) and more recently by external consultant Dr. Ian Sturgess. Appendix 2A highlights the ECIST review of the LRI ED, undertaken in March 2013.

Their findings identified that 12,600 patients were seen annually in a 6 bedded resuscitation area where 10 beds were deemed to be more appropriate; and 52,000 ambulance patients passed through a 16 cubicled majors area. Inadequate space results in patients being lined up in trolleys in the open floor space in majors and doubled up in cubicles. Size and poor adjacencies therefore inhibit the Trust's ability to smoothly move patients through the department to associated floors and medical assessment areas, resulting in delays to the patient journey and a poor patient experience. In addition, the medical assessment service (Rapid Assessment Unit (RAU) & Acute Care Bay (ACB)) is currently on the 5th floor of the Balmoral building and there is no access to X-ray or CT services within the ED, all of which further hinders an efficient patient pathway and increases risk to patients.

This FBC highlights the urgent need for change to the physical estate currently supporting the ED and associated medical assessment areas in order to improve patient flows, address capacity issues, optimise clinical adjacencies, reduce mortality and harm, and increase staff efficiencies.

1.2 Strategic Case

1.2.1 The Strategic Context

The Trust's organisational objectives are:

- High quality care for all – patient safety, improve outcomes & patient experience
- Quality Commitment – save lives, reduce harm, patient centred care
- 7 day a week consultant delivered services
- Optimising clinical service adjacencies to reduce avoidable deaths
- Reducing time patients avoidably spend in hospital
- Care closer to home through better integration with Community services
- Providing high quality services in a financially affordable & sustainable way
- Understand potential impact of alliances of care at local, regional & national levels

These objectives are underpinned by the following Investment objectives of this project:

- To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.
- To increase the productivity of the emergency care pathway at the LRI.
- To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a centralised service in modern accommodation.
- To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance.
- To provide an Emergency Floor that where practical, is compliant with NHS building guidance standards. Where the design is constrained then any derogation should be approved and signed off by the appropriate project lead.
- To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester.
- To improve the clinical adjacencies of services to optimise clinical safety and reduce clinical risk.
- To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an Emergency Floor that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce.
- To equip the Emergency Floor to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.
- To improve the environment and the experience of users (patients, visitors and staff) of Leicester Royal Infirmary Hospital's Emergency Department.
- To provide a solution that is aligned to the Trust 5 Year Estates Strategy DCP plan and Trust organisation as a whole.
- To deliver the development on time with minimal disruption to current service delivery.

Each of the project objectives has been formulated based upon the drivers for change and national, regional and local strategic directions, promoting efficiencies in practice and ensuring statutory, national, regional and local targets are achieved.

1.2.2 The Case for Change

Emergency Medicine is a secondary care specialty which provides immediate care for patients of all ages presenting with illness and injury of all severities[1].

Utilising the Better Care Together Case for Change Framework, the case for change for the Emergency Floor has been summarised in Figure 1B below:

[1] The College of Emergency (2011, February). What is Emergency Medicine? A guide.

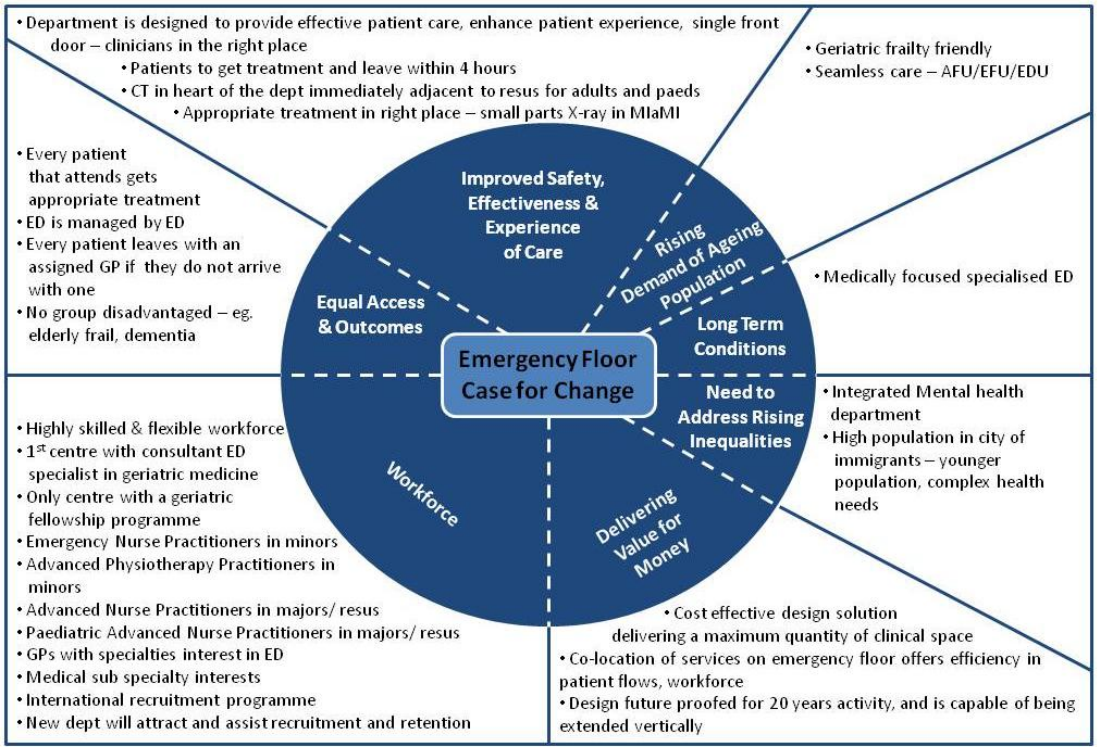


Figure 1.B Emergency Floor Case for Change

In order to provide the level of high quality emergency care and medical assessment services that comply with regulatory standards, it is essential that the Trust ensures that its patients can receive treatment and staff can work in a safe environment, and that patient treatment is efficient and timely in its delivery.

The following are key drivers for change:

- The increasing demand for emergency services is greater than the current capacity can provide. Historic trends in growth suggest a 5% annual growth in ED activity and 3.5% annual growth in medical assessment activity
- Requirement for single floor Emergency and Medical Assessment Department that incorporates key adjacencies and presence of diagnostics and medical assessment unit services on the same floor. This enables implementation of the developed model of care for both adults and children accessing emergency services
- Changes in the local and national demographics combined with the Trust's plan to remain an Emergency Care Centre for Leicester is impacting on increased emergency care demand
- The Trust requires additional capacity to reflect NHS national guidance. The Emergency Floor project reduces the risk of compromising compliance of other standards of care such as quality, infection control, privacy and dignity, emergency and urgent care standards and commissioning standards
- The Trust needs to be in a position to be named as a 'Major Emergency Centre' as outlined in the Urgent and Emergency Care Review November 2013 – End of Phase 1 Report (Keogh)

- The requirement to address the 4 hour target and ambulance to trolley transfer times will have a significant impact on Trust financial performance if capacity issues are not resolved
- Redevelopment and increased capacity will provide opportunities for the Trust to fulfil its strategic redevelopment programme

1.2.3 Capacity & Demand

The Trust has undertaken extensive work as part of the Better Care Together (BCT) programme, projecting ED and Medical Assessment activity for the next 5 year period. This work has concluded that UHL will see a 7.8% reduction in ED attendances over the next 5 years. This reduction is not applied uniformly across all areas of the department as high acuity resus/ majors patients are not likely to be diverted from the acute hospital setting into community services. However lower acuity patients such as those with minor injuries or minor illnesses could be diverted and therefore this is where the reduction in overall activity will be achieved.

At the time of writing the Developed OBC (August 2014), the Trust's Long Term Financial Model (LTFM) was not aligned to the BCT planning assumptions, as the LTFM had been submitted to the NTDA prior to the release of the BCT information. Therefore the two activity projections were not aligned, and the NTDA agreed that the Developed OBC would reflect two activity scenarios. However, it was outlined that the FBC would need to present a single scenario.

The Trust's ED attendances have continued to increase during 2014/15 and consequently neither model proposed in the Developed OBC reflects a realistic way forward. Following discussions with the CCGs, a pragmatic approach has been agreed which uses the forecast outturn activity for 2014/15 as the baseline; and then applies the BCT assumptions over the subsequent 5 years using 2015/16 as year 1. Years 6-20 will follow demographic growth in line with the Office of National Statistics (ONS); an annual increase of 1% for ED and Clinic activity, and 1.5% annually for medical assessment activity. This single model is outlined in more detail in Section 3.3.

In addition to the activity projections, the Trust has also undertaken activity analysis relating to hourly arrival percentiles. The 85th percentile number of hourly arrivals across the entire unit is in the region of 40 patients per hour. On occasions this volume may recur for two or three hours at a time. For the purposes of planning the new department, the capacity requirement was based on 95th percentile hourly arrivals. However as part of the Developed OBC this requirement was revised following NTDA feedback and is now based on 85th percentile hourly arrivals. It is important to note that efficiencies are impacted by the extent that patients occupy clinical spaces – resus bays, majors cubicles, etc – purely for the purpose of waiting (e.g. waiting for diagnostics or transfer, rather than for clinical intervention). In addition to capacity it is essential that adjacency requirements are considered and the associated impact on efficiencies and patient experience. This is particularly relevant for both the medical assessment and diagnostic services.

The UCC contract is currently held by George Eliot NHS Trust. The impact of this contract being held outside of UHL has been modelled in the FBC I&E through the reductions in activity, consistent with CCG assumptions regarding the activity shift that will occur. While the design has been based on the total activity figures (ED & UCC), the activity modelling in respect of a revenue position must exclude the UCC activity as

it is not currently provided by UHL. It should be noted that additional workforce efficiencies over and above those identified in the Workforce Plan could be achieved if there was a single clinical management structure for the ED and UCC. When the UCC contract is up for renewal, UHL will consider bidding to provide this element of the emergency pathway but this has not been assumed in the FBC.

The agreed activity model (percentage and actual numbers) for the FBC is shown in the Tables 1.1 and 1.2 below. As above, this excludes UCC activity.

Table 1.1 FBC Scenario - Activity Percentages

	Baseline	Year 1 2015/16	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
ED	FOT 2014/15	-8.30%	1.60%	1.00%	0.00%	0.30%
Medical Assessment		-3.49%	-0.41%	-1.21%	-0.14%	0.24%
Clinic Activity		0.00%	1.00%	1.00%	1.00%	1.00%

Table 1.2 FBC Scenario - Activity Figures

	Baseline FOT 2014/15	Year 1 2015/16	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
ED	145,837	133,733	135,873	135,601	135,601	136,008
Medical Assessment	35,984	34,729	34,585	34,166	34,120	34,203
TOTAL	181,822	168,462	170,458	169,767	169,721	170,210

1.2.4 Future Flexibility

Consideration of increased demand will provide opportunity for a solution that is flexible in functionality and that can provide capacity for current demand whilst enabling realisation of the 20 year capacity requirement.

A core component of the design solution will be the standardisation of the design of rooms within individual streams where possible, so that a wide range of practitioners can use any room for patient examination and treatment. A standardised design will also ensure that all staff are familiar with the location of equipment and facilities in any space.

For example within the ED, the Minor Injuries & Minor Illness, Eye Casualty, ENT area (MIaMIEE) represents a combined and totally flexible area for the Urgent Care Centre and Minors. Majors is designed in two sections, half of which will be closed at quieter times of the day. In the event that there is a lack of outflow from the ED into the hospital, half of Majors can flex into an assessment area. The assessment areas are being planned with generic beds (except the Acute Care Bay) for flexibility.

In addition the structural design is such that it can take an additional floor at a later stage, in line with the Trust's Development Control Plan.

1.2.5 Constraints & Dependencies

The constraints and dependencies relevant to the project are:

- **Better Care Together Programme:** the whole health economy has a strategy for improving Emergency Processes which this project must align to. This will include changing models of care to encourage fewer attendances to the Emergency Department
- **Budget:** the Trust has a limited capital budget, and must seek approval from the NTDA for any expenditure of over £5m of Treasury capital (i.e. excluding funds from donations).
- **Workforce:** the Trust has a strategic workforce plan as part of its 5 year Integrated Business Plan; assumptions for workforce changes, recruitment and retention within this project must align with the Trust's overall workforce plan.
- **Physical:** the existing accommodation is heavily occupied, making the splitting of the project into two phases an essential component of this project and the potential for disruption to the Trust organisation and infrastructure as a whole
- **Phasing:** difficult, and potentially reducing the ability to comply with national guidance
- **Timeliness:** the hospital will see continued pressure, both in terms of Urgent Care and ED attendances. From an operational perspective, the new facility must be ready as soon as practicably possible
- **Trust Transformation Programme:** Trust wide schemes for redevelopment of the Trust sites are all interdependent. This is the first scheme in a number of site-wide reconfiguration schemes.
- **Capital:** The project overall is dependent on the Trust securing the majority of capital through support from the NTDA
- **IM&T:** The project is dependent on the implementation of the Trust's Electronic Patient Record (EPR) project prior to opening.

1.3. Economic Case

The project comprises a new build Emergency Department and refurbishment of the existing emergency department to create a new medical assessment unit. Both the ED and medical assessment unit will have suitable adjacencies to ITU, Theatres and Base Wards.

The overall project is to be delivered in three phases:

- **Service Isolation / Diversion and Demolition:** part of the existing Victoria Building will be demolished to make way for the new build phase 1, including:
  - Moving substation 6 (currently serves A&E and Balmoral Building)
  - Moving substation 2 (currently serving Victoria Building)
  - Asbestos strip to service ducts
  - Isolation and diversion of services to ensure mains services are maintained to remaining buildings

- Demolishing the Langham wing of the Victoria Building whilst ensuring connectivity and interfaces between remaining buildings
- Demolishing St Luke's Chapel
- Demolishing and de-commissioning mechanical plant areas adjacent to St Luke's Chapel
- Demolishing the Link bridge from Jarvis

During the demolition works the existing below ground services duct will be protected and maintained to ensure continuous operation of the adjacent building serviced by the site infrastructure running within these ducts.

- **Phase 1 New Build ED Construction**: construction of a new purpose built ED, extending over the current location of Car Parks A and B, the Langham Wing of Victoria Building and St Luke's Chapel to create a new building for the ED, including the following departments for both Adults and Paediatrics:
  - Initial Assessment
  - Resuscitation
  - Majors
  - Minor Illness and Minor Injuries, Eye Casualty and Emergency ENT (MIaMIEE)
  - Diagnostic Imaging

- **Phase 2 Assessment Refurbishment**: once the ED has moved from its existing location to the new build, the vacated area will be refurbished /remodelled to create the medical assessment and geriatric assessment units. This area will include the following departments:
  - GP assessment area, acute medical clinics and ambulatory care centre (DVT & TIA)
  - RAU (Rapid Assessment Unit)
  - ACB (Acute care Bay)
  - EFU (Emergency Frailty Unit)
  - AFU (Acute Frailty Unit)

  Upon completion these areas will move from their current locations into this refurbished area.

1.3.1 Determining the Capacity

The revised activity assumptions for the FBC, compared to the Developed OBC, are:

- Use of 20-year planning horizon instead of 10-years
- Use of FOT 2014/15 as the activity baseline, year 0
- Use of Better Care Together growth profile for years 1-5 of the projections
- Use of Office of National Statistics (ONS) population growth for years 6-20 of the model

- Use of 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

Impact of Revised Scenario

- The original functional content of the proposed scheme, based on a 10-year planning horizon, remains sufficient to meet the activity projected at year 20 under the new activity modelling, with a small amount of spare capacity spread across a number of zones
- The original functional content has sufficient capacity to meet around 2% annual growth from years 6-20, should historic trends continue to be realised above the demographic growth of 1%.

This confirms that the originally proposed content and the design developed by the project team remain robust in the light of the FBC scenario assumptions. The slight capacity surplus in the proposed scheme is distributed across the project and its removal from the project would not warrant the cost, time and risk penalties associated with a full-scale redesign. This also provides future flexibility for the Emergency Floor.

1.3.2 Options Appraisal

An options appraisal process was undertaken, as described in the OBC, which reduced a long list of 13 options to a short list of 4 options, and then identified a preferred option, which is Option 3A – Victoria (new build ED, refurbished Assessment Unit).

The short listed options were:

- **Option 0:** Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
- **Option 1A:** Existing 1st floor refurbishment with some assessment provision elsewhere, (inc courtyard infill & extension)
- **Option 2C:** Demolition of Jarvis building & new build ED & refurbish assessment on single floor
- **Option 3A:** Demolition of Victoria building and part new build/part refurbish assessment on single floor

Table 1.3 Summary of Economic and Value for Money Appraisal

Criteria	Option			
	0	1A	2C	3A
Raw scores	51.18	131.74	129.64	148.71
Weighted Scores	2.27	6.74	6.27	7.54
Rank (non-financial)	4	2	3	1
Net present cost (NPC) (£k)	1,264,890	1,222,633	1,220,895	1,223,981
NPC per point score (£k)	557,220	181,400	194,720	162,332

Criteria	Option			
	0	1A	2C	3A
Rank (VFM)	4	2	3	1
Rank	**4**	**2**	**3**	**1**

Option 3A This option demonstrated through the non-financial appraisal process that the Trust is able to realise benefits and achieve strategic objectives and critical success factors of providing an appropriate solution to meeting current and future capacity demands for emergency care.

- This option lends itself to a detailed design process that provides essential departmental adjacencies
- Majors and Resuscitation areas can be located close to the front door and ambulances will have an ambulance only access to the department
- Adjacencies to the minor injuries and minor illness unit are enhanced and assessment services will maintain essential adjacencies within the department
- Paediatric emergency services demonstrated good adjacencies and separate paediatric entrance point is provided
- Ambulance access is provided on the same level as department entry which is essential for blue light access. The provision of an ambulance only access to the hospital department is seen as a better outcome to that which the other options can provide
- The single floor concept can be achieved with provision of diagnostics and assessment within the department and opportunities for flexibility and future proofing the design

This option provides an effective solution to the Trust's needs and in particular will be significantly more effective than the other options at providing flexibility, meeting capacity demands, enhancing the patient experience and emergency care pathway efficiencies. It also offers a solution with the least impact on the Trust's clinical and non clinical operations, DCP and strategic plans.

1.3.3 Estimating Capital Costs

The total capital costs for the preferred option at OBC stage and FBC stage are summarised in table 1.4 below.

Table 1.4 Capital Costs at OBC & FBC

Capital Costs	OBC Stage (£)	FBC Stage (£)
Construction	30,233,828	32,489,899
Fees	6,781,406	5,614,257

Capital Costs	OBC Stage (£)	FBC Stage (£)
Non Works Costs	0	76,021
Equipment	1,692,000	2,403,206
Planning Contingency	2,894,644	2,495,893
Total for approval purposes	41,601,878	43,079,276
Optimism Bias	0	0
Inflation	389,840	924,489
Total	41,991,719	44,003,765
VAT Recovery	-649,792	-674,738
Grand Total	**41,341,927**	**43,329,027**

1.3.4 Changes since the OBC

There have been no major design changes since the OBC. The main changes are as follows:

- Market testing of many construction works packages are priced higher than forecast
- Increase in equipment costs following more detailed review of transferable items
- Additional costs for highways as part of planning approval process
- Removal of fees in relation to previous options for the scheme
- Inclusion of non-works costs relating to the relocation of a bed store

For more details see Section 3.6.5.

Routes to Affordability Exercise

A review of the design vs outturn cost identified an increase in capital cost. To mitigate this, a ‘Routes to Affordability’ exercise was undertaken to provide a leaner solution for the scheme that still delivered the clinical functionality of the original intended design. The delivery team including UHL, RLB, ICL and technical advisors reviewed the overall project design including Phase 1 and Phase 2 and produced a summary of opportunities to deliver savings. These were then rated in agreement with the Trust in preference based on perceived impact to the scheme and saving level.

During the Routes to Affordability exercise, budget values were then agreed for each item whilst high level design impact assessments were carried out. Instruction was received from the Trust to incorporate only the viable items. Where savings have been realised these have been incorporated into the GMP value.

The Phase Two refurbishment works for assessment were designed and market tested on the basis of a full strip out to shell and new finishes and services throughout. The total cost plan allowance excluding VAT amounts to an allowance of £1,970/m^2. This was not an efficient approach to the design solution and did not represent value for money.

With the confidence of benchmarking, the team have been tasked with re-designing the area to use existing structure and services where possible, in line with the budget which has been allowed at £1425/m^2. For example, the Emergency Decisions Unit can stay in its existing location which delivers a leaner capital scheme, while still providing the required clinical functionality.

This review will be based on a set of updated operational policies which reflect the new GP assessment processes, and the need for the Emergency Frailty Unit and the Acute Frailty Unit to be in the same space to allow workforce efficiencies.

Therefore, capital costs include a provisional sum for the Phase Two works which will drive the design solution to an achievable budget for the type of refurbishment works required (£1425/m^2).

More detail can be found in the Estates Annex at Appendix 2Q.

1.3.5 Guaranteed Maximum Price

The agreed Guaranteed Maximum Price (GMP), which includes inflation and VAT, of Interserve Construction Limited, the Principal Supply Chain Partner (PSCP), for the design and construction of the Emergency Floor at Leicester Royal Infirmary includes all of the costs to date, in addition to all anticipated costs in completing the design and construction of the facility.

The GMP offer made by Interserve in 2014 is based on a construction start date of July 2015. Interserve have confirmed work must start within the following 3 months to ensure the GMP remains the same. However the impact of not achieving this date will result in a delay, creating additional costs. The GMP offer can be found at Appendix 3D

The total project capital cost is £43.3m and this is broken down into a number of elements (including the GMP) as set out in the table above and in the FB forms which can be found at Appendix 3A, 3B and 3C.

1.3.6 Revenue Costs

The revenue changes between the OBC and FBC have been reviewed and can be seen in detail in the Economic Case. The following table reflects the position at FBC:

Table 1.5 FBC Revenue Costs

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Income change	**1,386**	**239**	**263**	**(80)**	**(127)**
Expenditure					
Agency	0	840	1,844	2,347	2,347
Workforce efficiencies	0	356	626	1,373	1,373
Additional clinical costs from new development	0	0	(183)	(734)	(734)
Additional maintenance costs of equipment	0	0	(58)	(271)	(383)
Pay and non pay increases from changes in activity	0	320	332	378	379
Depreciation	177	177	(25)	(637)	(637)
Rate of return	45	(334)	(686)	(720)	(698)
Total change in expenditure	**222**	**1,360**	**1,851**	**1,736**	**1,646**
Total Net Change	**1,608**	**1,599**	**2,114**	**1,656**	**1,520**

The net position of the FBC is significantly better than the OBC as a result of revised assumptions on income loss.

1.3.7 Summary of Position compared to OBC

The changes between OBC and FBC are as follows:

Table 1.6 Summary of Position compared to OBC

	OBC	FBC	Comment
Capital Costs	£41,342k	£43,329k	Driven by additional equipment market testing and section 278 works re highways
Annual Revenue Costs (2018/19)	£44,580	£44,583	Driven by changes in activity, additional costs of equipment maintenance partially balanced by reductions in capital charges in FM costs

1.3.8 Compliance with Capital Investment Manual & NTDA Thresholds

If the capital cost exceeded 5% of the costs stated and approved in the OBC (£41.6M) there would be an automatic lapse of approval of the OBC. As can be seen in table 1.4 above, the capital total for approval purposes has increased for £41.6M to £43M. This is an increase of £1.4M which is 3.5% of the costs approved at OBC stage. Therefore the capital cost increase is within the tolerances allowed.

It the revenue cost exceeded 10% of the costs stated and approved in the OBC, there would also be an automatic lapse of approval of the OBC. The revenue cost position has only marginally changed between OBC and FBC and is within the parameters.

1.4 Commercial Case

1.4.1 Procurement Strategy

The scheme will be procured through UHL's framework partnership with Interserve FM and assigned to Interserve Construction Limited.

Under the bespoke framework, Interserve Construction Ltd is appointed as principal contractor for the delivery of projects; commercial arrangements and contracts are pre-agreed to cover commissioning of the business case through to final delivery of the asset using an NEC3 Option C Form of Contract (Target Contract with Activity Schedule). Cost savings are split between the Trust and the Client based on previously agreed percentages which will engender a spirit of partnering and collaboration within the Project Team. The risk of cost overrun is transferred to Interserve once the GMP has been agreed and construction stage commenced.

Project risk is dealt with openly from the outset of the project and the client; Interserve and the Design Team are encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it. This should be a proactive process throughout the delivery of the project.

Under the framework, Interserve has:

- Taken single point responsibility to manage the design and construction process from completion of OBC through to project completion
- Assembled a dedicated team from its supply chain of experienced health planners, designers and specialists, to successfully deliver facilities that will benefit patients and staff alike
- Provided benefits of experience of long term partnering arrangements that will continue throughout the life of the project
- Committed to identifying construction solutions that will assist in the implementation of improved service delivery, best practice and delivering best value

Interserve and UHL have worked together through the full business case (FBC) stage to develop and agree a guaranteed maximum price for delivery of the scheme. This reflects:

- Fees for professional advice such as design and cost management
- Market tested packages for construction works on an open book basis

The GMP has been assessed for overall value for money by cost consultants acting for UHL (Rider Levett Bucknall - RLB). This will take into account elements such as:

- Prevailing rates for similar works nationally and locally
- Published cost indices
- Knowledge of the cost of work in the hospital from other recent schemes
- Prime contractor and client retained risks as identified in the joint risk register

It was agreed that the development of the GMP would be run in parallel with the development of the Works Information and this would be undertaken in a fully open book / collaborative environment, such that a minimum of three quotations would be obtained for all Works Packages making up at least 80% of the GMP.

Package responses were assessed by Interserve Construction Ltd in conjunction with the Trust's advisors RLB to ensure the 'Best Value' tender was included in the GMP. The assessment was not only be based on price but also programme, design/ technical proposals and likely risk. Interserve and RLB agreed a formal assessment proposal for each package. Tenders were benchmarked appropriately.

Should the scheme not proceed, the Trust will own the design at point of termination but will be liable for Interserve costs up to that point, in line with contractual commitments made during commissioning of the project.

1.4.2 Key Factors Affecting Outcomes

- **Planning Permission:** the preferred option requires planning consent, which was obtained on 24th September 2014 subject to Planning Conditions. Appendix 4A shows the Planning Approval and Planning Conditions; Appendix 4B shows the Planning Conditions Tracker.
- **BREEAM:** the project team have worked alongside an accredited BREEAM assessor throughout the design process to ensure requirements are considered in a timely manner. The project has been awarded an Interim Certificate – Design Stage by the BRE showing a score of 56.2%, Very Good. See Appendix 4C for the Interim Certificate.

1.5 Financial Case

1.5.1 Capital Costs

The capital costs of the preferred option total £43.3M including forecast out-turn inflation. Below is an analysis of the total costs.

Table 1.7 Summary of Capital Costs

Capital Costs	Option 3A Victoria (£)
Construction	32,489,899
Fees	5,614,257
Non Works Costs	76,021
Equipment	2,403,206
Planning Contingency	2,495,893
Sub Total	43,079,276
Optimism Bias	
Inflation	924,489
Total	44,003,765
VAT Recovery	-674,738
Grand Total	**43,329,027**

1.5.2 Financing

Table 1.8 below sets out the cashflow associated with the scheme together with sources of funding. This shows that the Trust has clearly identified its capital requirements and has also identified relevant sources of funding.

As can be seen below the Trust has currently funded the initial development costs from its own resources but is seeking funding for the full costs of the scheme. Further details to support these figures are within Appendix 5A.

Table 1.8 Sources and Applications of Funds

	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	2018/19 £	TOTAL £
Capital Expenditure	568,764	6,368,024	17,698,095	18,341,114	1,027,768	-674,738	**43,329,027**
Funded By							

PDC/Public Loan			24,634,883	18,341,114	1,027,768	-674,738	**43,329,027**
Trust Resources	568,764	6,368,024	-6,936,788				**0**
Total Funding	568,764	6,368,024	17,698,095	18,341,114	1,027,768	-674,738	**43,329,027**

1.5.3 Income & Expenditure

Within the first five years, activity levels are predicted to fall based on the assumption of implementation of Better Care Together Plans to divert attendances from ED to alternative providers of care in both primary and community settings. It is anticipated that after this point there will be a small increase in activity driven by changes in demographics and acuity levels. This initial decrease in activity will impact on staffing and non pay costs. These shifts in activity by type have been modelled and will be used to calculate the most appropriate staffing levels taking into account the risks of a 'boom and bust' approach to workforce planning given the lead in times for education and training.

Table 1.9 shows a summary of the impact of these assumptions on the Trust's I&E over the first 5 years. More detailed information on impact can be seen in Table 1.10 below.

Table 1.9 5 Year Financial Summary

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Income change	**1,386**	**239**	**263**	**(80)**	**(127)**
Expenditure					
Agency	0	840	1,844	2,347	2,347
Workforce efficiencies	0	356	626	1,373	1,373
Additional clinical costs from new development	0	0	(183)	(734)	(734)
Additional maintenance costs of equipment	0	0	(58)	(271)	(383)
Pay and non pay increases from changes in activity	0	320	332	378	379
Depreciation	177	177	(25)	(637)	(637)

Rate of return	45	(334)	(686)	(720)	(698)
Total change in expenditure	**222**	**1,360**	**1,851**	**1,736**	**1,646**
Total Net Change	**1,608**	**1,599**	**2,114**	**1,656**	**1,520**

The Financial Case identifies Income and Expenditure assumptions over the 20 year period.

1.5.4 Workforce Plan

Key to delivery within financial balance is the development of an appropriate workforce to support activity levels within the new Emergency Floor. The workforce plan has been developed in line with assumptions made in the OBC and fully aligns with the capacity and financial models presented in this FBC. The detailed workforce plan is attached as Appendix 5C. This plan describes the overarching process for determining the proposed revenue cost reduction and includes details of both financial and non financial benefits arising from the development of the emergency floor. The plan also includes potential risks and actions to mitigate these.

Overall the aim of the workforce plan is to:

- Ensure the appropriate supply and skill mix to consistently deliver the 95% ED target, and a number of individual key performance indicators within different components of the Emergency Floor
- Ensure the right staffing levels are available in all components of the floor to ensure the correct ‘gearing’ to achieve the identified standards and manage surges in activity
- To ensure an efficient model of workforce provided at less cost per activity than the current model
- To ensure the workforce model provides an education, training and career framework model that supports a sustainable future supply of workforce, taking into consideration the fragility of the ED workforce and the need to recruit and retain in the future.

A number of assumptions have been built into the workforce planning processes for the Full Business Case for the Emergency Floor. These are highlighted in section 5.5.

1.5.5 Impact on Trust Balance Sheet

Table 1.10 below sets out the impact on the Trust’s balance sheet. Further details to support these figures are within Appendix 5A.

Table 1.10 Impact on Trust's Balance Sheet

	2013 /14 £	2014 /15 £	2015 /16 £	2016 /17 £	2017 /18 £
Assets Under Construction	568,764	6,368,024	17,698,095	18,341,114	353,031
Impairments on new building coming into use (DV likely revaluation)				-15,718,000	
Impairment on partial demolition of Victoria based m^2		-2,424,261			
Depreciation				-201,870	-807,481
Change to Fixed Assets	568,764	3,943,762	17,698,095	2,421,244	-454,450

As can be seen, the demolition of part of the existing Victoria Building will lead to an impairment in the first instance and this has been based on the square meterage demolished as a percentage of the total building area.
The new Emergency Floor project is expected to be available in June 2017. Prior to this it is treated as an asset under construction.

Once fully operational, we have assumed that as a result of the District Valuer valuation there will be an impairment of 38%.

The value of these impairments is shown in table 1.11 below; further details to support these figures are within Appendix 5A.

Table 1.11 Value of Impairments

Impairments	£K
Demolitions	2,424
New asset coming into use	15,718
Total	**18,142**

1.5.6 Capital Charges & Impact of Loan Option

Details on capital charges and the impact of a loan option can be found in the Financial Case (Section 5) and Appendix 5A.

1.5.7 Sensitivity

A key sensitivity for the Trust is the activity levels. The Trust has set out in Section 5.4 the impact on the I&E position of activity based on the Better Care Together scenario. This assumes a 7.3% reduction in activity in 2015/16, and this has to be contrasted with an underlying increase in ED activity of circa 8%. An 8% increase in activity approximately equates to an increase in income of £3 million. The Trust has assumed that the cost of delivering the additional activity would be circa £1.65 million. Any level of activity higher than that assumed in the business case therefore will improve the Trust's income and expenditure position.

1.5.8 Affordability

In developing the FBC efficiencies have been identified which demonstrates the case is affordable to the Trust. The efficiencies, outlined in table 5.4, have been developed through detailed activity, capacity and workforce planning.

1.6 Management Case

1.6.1 Project Governance Arrangements

Project Governance arrangements have been established to reflect national guidance[2] and the Trust's own Capital Governance Framework, as shown in the figure below:

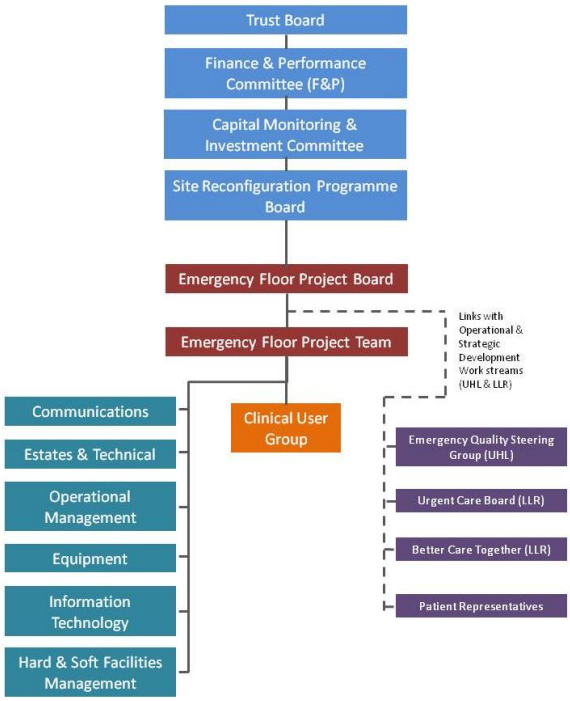


Figure 1.C UHL Capital Governance Framework

[2] Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency & Reform Group)

Regular Progress Reports are submitted to the Capital Planning Group, Executive Strategy Board and Trust Board for onward reporting and management within the established Trust management structure.

1.6.2 Core Groups & Responsibilities

The roles and responsibilities for the main project groups are summarised as follows:

Emergency Floor Project Board

The membership of the Project Board is:

Table 1.12 Emergency Floor Project Board Membership

Member	Title
Dr Kevin Harris	Chair/ Medical Director
Richard Kinnersley	Major Capital Projects Technical Director, UHL
Nicky Topham	Project Director/ Programme Director of Reconfiguration, UHL
Paul Traynor	Director of Finance
Phil Walmsley	Head of Operations
Dr. Catherine Free/ Jane Edyvean	Senior User/ Emergency & Specialist Medicine CMG Representative
Dr. Andrew Furlong	Senior User/ Deputy Medical Director
Dr. David Yoemanson	Senior User/ Woman's & Children's Divisional Representative
John Clarke	Chief Information Officer
Ian Crowe	Non Executive Director
Michael Pepperman	Healthwatch representative
Tiff Jones	Head of Communications

Key roles and responsibilities include:

- Responsibility for delivering the project within the parameters set within the business case
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders
- Providing the strategic direction for the project
- Ensure continuing commitment of stakeholder support
- Key stage decisions
- Progress monitoring

Monthly progress reports, including projections of forthcoming key activities and decisions, will be submitted to the Project Board by the Project Director.

Emergency Floor Project Team Meeting

The membership of the Emergency Floor Project Team Meeting is the work-stream leads:

Table 1.13 Emergency Floor Project Team Membership

Member	Title	Role (work-stream lead)
Nicky Topham	Project Director, UHL	Chair
Richard Kinnersley	Major Capital Projects Technical Director, UHL	Estates & Technical
Jane Edyvean	CMG General manager	Workforce, activity & clinical commissioning
John Clarke	Chief Information Officer	IT
Richard Pitt	Head of Procurement	Equipment
Tiff Jones	Communications Manager	Communications
Louise Gallagher	Workforce Manager	Workforce professional advisor
Paul Gowdridge	Head of Strategic Finance	Finance
TBC	Interserve FM	Hard & Soft FM

This fortnightly group is a designated committee appointed by the Project Board, with responsibilities which ensures:

- Operational delivery of the scheme to time, quality and budget.
- Decision on matters for escalation for ESB and Trust Board direction/ information
- Management of risks and issues and escalation of appropriate matters for executive direction/ approval
- Drawing together the outputs of the Working Groups and coordination of cross cutting issues

Working Groups

Working Groups will be convened by the leads as above to provide advice and direction to the detailed design process. Their roles are summarised in Section 6.

1.6.3 Project Plan

The Project Programme is intended to deliver the project by summer 2017, though this timeline is predicated on meeting key submission and approval dates to both the Trust Board and NTDA. The full programme can be found at Appendix 6B. The milestones for this project are set out below.

Table 1.14 Project Milestones

Milestone	Date
Outline Business Case presented to Trust Board Development Session	21st Nov 2013
Outline Business Case presented for Trust Board approval	28th Nov 2013
Outline Business Case sent to the NTDA	Dec 2013
Outline Business Case presented to CCGs & UCB	Dec 2013
Commence Detailed Design & Full Business Case	Feb 2014
Submission of Planning Application	2nd Jun 2014
Trust commit to place order for early procurement items	2nd Jun 2014
Trust Board approval of Developed Outline Business Case	28th August 2014
Trust commit to place order for early works (isolation, diversion)	5th Sept 2014
LCC Planning Approval	24th Sept 2014
Trust commit to place order for demolition works	25th Sept 2014
Commence isolation, diversion, demolition works	December 2014
NTDA approval of Developed Outline Business Case	6th Jan 2015
Trust Board approval of Full Business Case	8th Jan 2015
NTDA submission of the Full Business Case	9th Jan 2015
NTDA approval of the Full Business Case	19th March 2015
Isolation, Diversion, Demolition complete	May 2015
Commence construction (Phase 1 – ED)	May 2015
Complete construction (Phase 1 – ED)	Winter 2016
Commence construction (Phase 2 – Medical Assessment & Frailty Units)	Winter 2016
Complete construction (Phase 2 – Medical Assessment & Frailty Units)	Summer 2017

1.6.4 Use of Special Advisors

Special advisers have been used in a timely and cost-effective manner in accordance with the Treasury Guidance.

Table 1.15 External Advisors

Emergency Floor Development		
1	Interserve Construction Ltd	Building/ Construction Supervisors
2	Interserve Engineering Services	MEP Detailed Design & Installation

3	Rider Levett Bucknall	Project Management & Cost Advisors
4	Rider Levett Bucknall	Trust Cost Advisors
5	Capita	Architects
6	Capita	Cost Consultants
7	Capita	Business case / Finance analysis
8	Capita	Structural Engineers
9	Capita	Mechanical and Electrical Engineers
10	Capita	CDM

1.6.5 Stakeholder Engagement

A Communications Strategy (Appendix 6C) has been developed in consultation with the Trust's Communications and Marketing Team; this identifies key stakeholder groups and key messages that need to be shared at key milestones in the project. This is an extremely important plan for the Trust since the Emergency Floor project represents the first large capital project being undertaken as part of a wider Trust reconfiguration plan.

1.6.6 Outline Arrangements for Change & Contract Management

The Change Control procedures will be undertaken in accordance with the flow charts identified within the NEC3 contract framework.

Project specific versions of these will be prepared identifying the basic process in relation to:

- Issue of Project Manager's Instruction
- Contractor confirms price and programme implications within 3 weeks
- Project Manager raises Compensation Event within 2 weeks if in agreement
- Client Accepts Compensation Event and signs accordingly
- Contractor updates Programme

1.6.7 Outline Arrangements for Benefits Realisation

The delivery of benefits will be managed through the Emergency Floor Project Board. A copy of the benefits realisation plan can be seen in Section 2.17; this sets out who is responsible for the delivery of specific benefits, when they will be delivered, and how achievement of them will be measured. The key opportunity is presented by the new design for facilities, which will ensure sufficient capacity to meet demand, efficiencies in service delivery, compliance to standards and minimised disruption to overall Trust operations.

1.6.8 Outline Arrangements for Risk Management

All projects are subject to risk and uncertainty. Successful project management should ensure that major foreseeable risks are identified, their effects considered and actions taken to remove, or mitigate the risks concerned.

Risks will be classified as:

- Client – these will be the responsibility of the Project Board to manage and monitor
- Contractor – a project specific risk register will be set up for the Project. These will be the responsibility of the Contractor to monitor and will form part of the GMP

The qualification of the costs of identified risks will enable the calculation of a realistic client contingency.

A pro-active risk management regime will be employed throughout the project. It is essential on any project (in particular one of this size and complexity) that the risk management process involves all key members of the project team.

The current risk register can be found in Appendix 2T.

1.6.9 Outline Arrangements for Post Project Evaluation

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Emergency Floor Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business case.

The outline arrangements for post Project Evaluation (PPE) have been established in accordance with best practice. The trust will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project.

1.6.10 Gateway Review Arrangements

A Health Gateway Review 2: Delivery Strategy was undertaken and associated report issued to the Project SRO on the 18th June 2014 (Appendix 6E). A Delivery Confidence Assessment of AMBER was issued by the review team along with recommendations for consideration/ implementation.

The recommendations from the Gateway Review have been completed.

The next Health Gateway Review, Gateway 3 Investment Decision is recommended once GMP is received and the Full Business Case is complete and ready for Trust Board and other approvals. This will be in January 2015.

1.6.11 Contingency Plans

The Trust has a framework for Business/Service Continuity. In this instance, the Emergency Care Directorate ensures that the Trust's emergency care service contingency plans are in place for the event of any disruption.

The Trust's framework ensures the Trust can comply with the business continuity provisions of the Civil Contingencies Act 2004. Contingency plans have been developed to ensure the Trust can continue to deliver an acceptable level of service of its critical activities in the event of any disruption.

In the event that this project fails and the ED is not re-developed, the Trust will continue to implement and realise the benefits of its current Emergency Care action plan. The Trust will implement the Do Minimum albeit limiting in achieving capacity requirements and efficiencies, however it will enable a continuation of Emergency services within its existing facility.

1.7 Stakeholder Support

This Emergency Floor project is a key component of the urgent care work-stream of the Better Care Together (BCT) programme. The Overview Scrutiny Committee (OSC) has supported this case through presentation of the BCT programme.

The CCGs will be asked to provide written support of this FBC (Appendix 1A – to follow).

1.8 Recommendation

The Trust Board is recommended to approve this business case for submission to the NTDA.

Signed: .....

Senior Responsible Officer

Date:.....

Senior Responsible Owner
Project Team

2 | The Strategic Case

2.1 Introduction

This document sets out University Hospitals Leicester NHS Trust's (hereafter referred to as 'the Trust' or 'UHL') proposals to invest in a fit for purpose, modern Emergency Floor for the provision of emergency services at its Leicester Royal Infirmary (LRI) site.

In line with the national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its Emergency Department (ED). This has resulted in many patients waiting for excessive periods and performance being well below the national standard of 95%; this reflects poor quality of care for patients, increased risk of harm, increased mortality, reduced clinical effectiveness, an unacceptable delay in treatment and compromised patient safety.

In partnership with local commissioners, UHL has instigated a number of short term measures to improve performance, such as the addition of adult medical assessment beds and a new GP assessment clinic to alleviate current pressures. UHL has set out a clear vision for the future of the emergency care pathway and is undertaking a programme of change to redesign processes within the existing footprint and built environment, but there is still an issue with the design and size of the current ED and associated medical assessment areas in their entirety. They are deemed totally inadequate to cope with demand, as previously stated by the Emergency Care Intensive Support Team (ECIST) and more recently by external consultant Dr. Ian Sturgess. Appendix 2A highlights the ECIST review of the LRI ED, undertaken in March 2013.

Their findings identified that 12,600 patients were seen annually in a 6 bedded resuscitation area where 10 beds were deemed to be more appropriate; and 52,000 ambulance patients passed through a 16 cubicled majors area. Inadequate space results in patients being lined up in trolleys in the open floor space in majors and doubled up in cubicles. Size and poor adjacencies therefore inhibit the Trust's ability to smoothly move patients through the department to associated floors and medical assessment areas, resulting in delays to the patient journey and a poor patient experience. In addition, the medical assessment service (Rapid Assessment Unit (RAU) & Acute Care Bay (ACB)) is currently on the 5th floor of the Balmoral building and there is no access to X-ray or CT services within the ED, all of which further hinders an efficient patient pathway and increases risk to patients.

As a consequence, there is an urgent need for change to the physical estate currently supporting the ED and associated medical assessment areas in order to improve patient flows, address capacity issues, optimise clinical adjacencies, reduce mortality and harm, and increase staff efficiencies.

2.1.1 Clinical objectives of the project

The new build represents an opportunity to change the service currently provided to acutely unwell and injured patients presenting to UHL. The aim is to ensure the same, evidence based, high quality care is provided regardless of origin of referral; that experience and knowledge is not only pooled but utilised to its greatest benefit and to reduce inequality and inconsistency in financial terms. Patients will be assessed on arrival and streamed according to their condition to the correct service:

- primary care
- community care
- ambulatory emergency care
- observation and short stay units (if a relatively short period of hospital inpatient care is required)
- full admission to hospital

Senior decision makers (SDMs) at the front door will work effectively across all areas. Review by SDMs, earlier in the patient journey has been shown to reduce mortality, risk of harm, overall admission rates and length of stay[3].

All adult GP referrals will be screened by a consultant at the GP referral unit, and where further assessment or admission is required they will be directed to the appropriate unit to be seen by a specialist team which will lead to a better patient experience and outcome.

Co-location of departments which constitute the Emergency Floor will facilitate collaborative working. For example, the location of units for frail patients in close proximity to Majors will enable rapid assessment and provide a specialist opinion at the start of the patient jounrney, therefore giving the patient the best opportunity to have the right care, in the right place, from the start.

The design of the floor will be clinically and stakeholder led to ensure functionality. Areas will be 'frail friendly' to accommodate the growing number of frail older people attending ED and the growing number of patients with dementia. This will include flooring, colours, lighting and signage which will aid orientation and has been proven very influential on patient experience in other units. The children's areas will also be carefully designed to reflect consistency with the children's hospital branding.

Patient Vignettes

- **Emergency Department:** *'I can't look another relative in the eye as they wait anxiously for their relative to go the ward having waited patiently in an overcrowded and busy ED. They haven't even been able to sit down. You know what they are thinking: why is it like this? There needs to be more space but they are too polite to voice their concerns. In the future, the new department will provide the staff, patients and relatives the space that they need to provide dignity and privacy.'*

  Dr Jonathan Acheson, Emergency Medicine Consultant

- **Geriatrics (before front door Comprehensive Geriatric Assessment (CGA)):** *'Vera, an 80 year old lady attended the ED following a fall. A primary survey revealed no major injuries, and there was no evidence of any head trauma. The assessing doctor felt that the fall was mechanical and that there was no suggestion of any syncope. Near patient tests revealed slightly low sodium. The doctor assessing Vera felt that she was safe to go home and arranged for her daughter to collect her, and asked that they see the GP in a week to get the sodium levels looked into. Vera was taken home by her daughter feeling reassured, but had a second fall two days later; on this occasion she injured her*

[3] Geelhgood et al, 2008

hip; she was again taken to the ED where an x-ray revealed a hip fracture that required surgery. The surgery was successful, but post-operatively Vera developed delirium thought to be related to infection; antibiotics were given which caused some diarrhoea, but all eventually settled. After a period of convalescence in a community hospital, Vera returned home after 6 weeks, although her confidence remained low.'

Dr Emily Laithwaite, Consultant Geriatrician.

- **Geriatrics (after front door CGA, same doctor assessment):** *'The admitting nurse had completed a frailty screening tool which indicated that Vera had some cognitive impairment, polypharmacy and needed help with activities of daily living indicating that she was at high risk of readmission (ISAR score 3). Whilst the doctor was awaiting the blood test results, the nurse arranged for a review by the frailty team. The frailty nurse undertook a holistic assessment, which revealed that Vera had significant cognitive impairment (MMSE 20/30). The frailty nurse phoned Vera's daughter who confirmed what appeared to be a history of undiagnosed dementia, and also mentioned how stressed she had been over recent weeks, as she was the main carer for her mum. There had been several falls and Vera's confusion had been worsening over the last few days. The frailty nurse asked the duty geriatrician to review Vera, this led to diuretics being stopped as a likely cause of the low sodium. A referral to the falls service was made; in addition the intermediate care team were asked to see Vera at home and support her for a few weeks. The geriatricians discussed Vera's case with her GP, who was happy to monitor the sodium levels and fluid status – he also agreed to refer to the memory clinic. Vera left the department and made a gradual, but uneventful recovery at home.'*

  Dr Emily Laithwaite, Consultant Geriatrician.

This business case highlights the current arrangements for provision of emergency services, projected requirements over the next 20 years and proposes a preferred option as a solution.

2.2 Structure & Content of the Document

This business case has been prepared using the agreed standards and format for business cases, as set out in DH guidance and HM Treasury Green Book. The case comprises the following key components:

- **The Strategic Case** | This sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme
- **The Economic Case** | This demonstrates that the organisation has selected the choice for investment which best meets the existing and future needs of the service and optimises value for money (VFM)
- **The Commercial Case** | This outlines the content and structure of the proposed deal
- **The Financial Case** | This confirms funding arrangements and affordability and explains any impact on the balance sheet of the organisation

- **The Management Case** | This demonstrates that the scheme is achievable and can be delivered successfully to cost, time and quality

Part A: The Strategic Context

2.3 Introduction

This section provides an overview of the context in which the Trust provides its services and the strategic guiding principles, directives and policies that ensure clinical quality standards are met. The intention is to provide an overview of the Trust and its strategic objectives, to highlight current emergency care service delivery and set the context for this business case. It also provides an overview of the driving policies and guidance documents at National, Regional and Local level.

2.4 Organisational Overview & Background

2.4.1 University Hospital Leicester NHS Trust

UHL is one of the largest teaching hospitals in the country and operates across three main sites; the Leicester Royal Infirmary, Leicester General Hospital, and the Glenfield Hospital. It is the only acute Trust serving the diverse local population of Leicester, Leicestershire and Rutland (LLR); equating to approximately 1 million residents. The majority of the population is split as follows:

- Leicester City – population 304,722
- Leicestershire County and Rutland – population 685,100

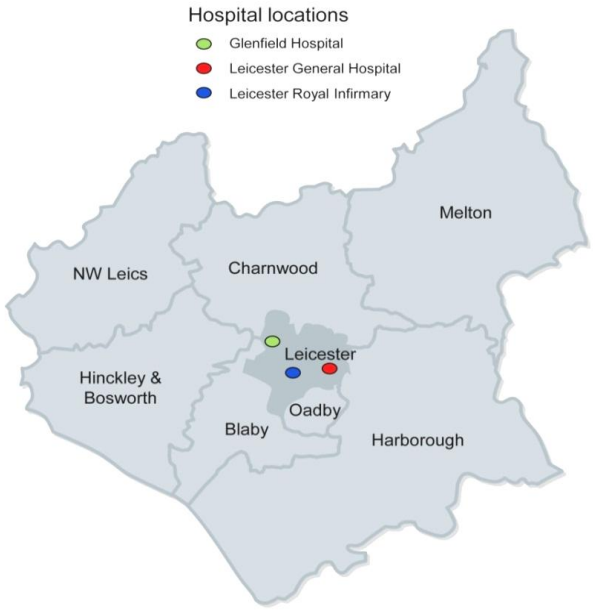


Figure 2.A University Hospitals of Leicester NHS Trust Locations

The Trust provides a wide range of services across its three main sites, which are summarised in table 2.1 below:

Table 2.1 Trust Services

Leicester Royal Infirmary		Leicester General Hospital	Glenfield Hospital
General Surgery	Vascular Surgery	Neurology	Paediatric Oncology
Gastroenterology	Plastic Surgery	Urology	Respiratory Medicine
Trauma	Clinical Haematology	Nephrology	Adult Cardiology

Leicester Royal Infirmary		Leicester General Hospital	Glenfield Hospital
Obstetrics	Dermatology	Emergency Surgery	Breast Surgery
Acute Medicine	Infectious Diseases	Obstetrics	Breast Screening
Well babies	Genetics	Sports Medicine	Orthodontics
Rheumatology	Emergency Surgery	Hepatobiliary	Restorative Dentistry
Ophthalmology	Immunology	Elective Gynaecology	Clinical Support Services
Oncology & Radiology	Stroke Medicine	Elective Orthopaedics	Cardiothoracic Surgery
Maxillofacial Surgery	Elderly Medicine	Diabetes Centre of Excellence	Paediatric Congenital & PICU
Adult and Paediatric A&E	Clinical Support Services	End Stage Renal Failure	Respiratory
Paediatric Medicine & Surgery	Central Pathology	Renal transplantation	Cardiology
Emergency Gynaecology	Genito-urinary Medicine	Clinical Support Services	CCU
Ears, Nose & Throat (ENT)			
Diabetes & Endocrinology			

2.4.2 Clinical Management

The Clinical Management is structured into seven management groups, with each group led by a Senior Consultant in the role of Director. The seven Clinical Management Groups (CMGs) are as follows:

- CHUGS – Cancer, Haematology, GI Medicine and Surgery
- ESM – Emergency and Specialist Medicine
- CSI – Clinical Support & Imaging
- ITAPS – Critical Care, Theatres, Anaesthesia, Pain and Sleep
- MSS – Musculoskeletal and Specialist Surgery
- RRC – Renal, Respiratory and Cardiac
- Women's and Children's

Each Director has a clinical background and works in a clinical environment as well as providing overall leadership for the CMG. Alongside the director the CMGs each have a Head of Nursing and a CMG General Manager.

The clinical management of the organisation is supported by the following corporate directorates:

- Marketing & Communications
- Medical
- Finance & Business Services
- Human Resources & Learning and Organisational Development
- Operations
- Nursing
- Strategy including Capital projects
- Corporate & Legal Affairs
- IMT
- Facilities Management

2.4.3 Activity & Finance

2013/14 was a challenging year both operationally and financially and the Trust reported a deficit for the first time since the organisation was formed in 2000. UHL provides hospital and community based healthcare services to patients across Leicester, Leicestershire and Rutland, and specialist services to patients throughout the UK. As such, main sources of income are derived from Clinical Commissioning Groups, NHS England, and education and training levies. The Trust is actively engaged with key stakeholders to implement NHS policy to improve health services in the local area through a range of formal and informal partnerships.

- **Financial review for the year ended 31 March 2014**

The Trust did not meet all of the financial and performance duties for 2013/14:

- Balancing the books: delivery of an income and expenditure deficit of £39.7m
- Managing cash: undershot the revised External Financing Limit by £1.3 million, which is permissible
- Investment in buildings, equipment and technology - invested £36.6 million in capital developments

- **Performance against financial plan**

UHL delivered a £39.7m deficit for the year against a planned surplus of £3.7m. The Annual Operating Plan (the Plan) included income of £745.3m (excluding the impact of donated assets) and expenditure of £741.6m. The principal drivers for the deficit are:

- Non-receipt of £15m strategic transitional support
- £5.3m less non-recurrent transformation funding from commissioners
- £14.3m relating to in year operating cost pressures and a deliberate investment in nurse staffing to sustain quality of care and patient safety standards
- Contractual penalties and deductions of £5.2m including a £3.4m increase in MRET deductions

The final year end position showed the following (excluding the impact of donated assets):

- Total income £770.4m actual; £25.1m over plan
- Total expenditure £809.9m actual; £68.3m over plan

- Capital expenditure £36.6m against a revised capital resource limit of £36.6m
- Closing cash balance £515k against a revised target of £500k

▶ Capital expenditure 2013/14

The chart below shows capital expenditure (excluding adjustments for donated assets) for 2013/14 which was £36.6m, a £11.2m (47.6per cent) increase over the 2012/13 total of £25.4m. This increase was due to the following material items of expenditure:

- £3.15m for the initial works and planning towards the Emergency Floor development at the LRI
- £2.36m for the phased reconfiguration of maternity areas at the General and LRI
- £1.67m for the creation of new theatre admissions and assessment area at the LRI
- £0.60m for new ventilation systems for cancer wards in the Osborne building to reduce infections
- £1.91m for new Combined Heat & Power (CHP) units funded by the Department of Health to generate green energy

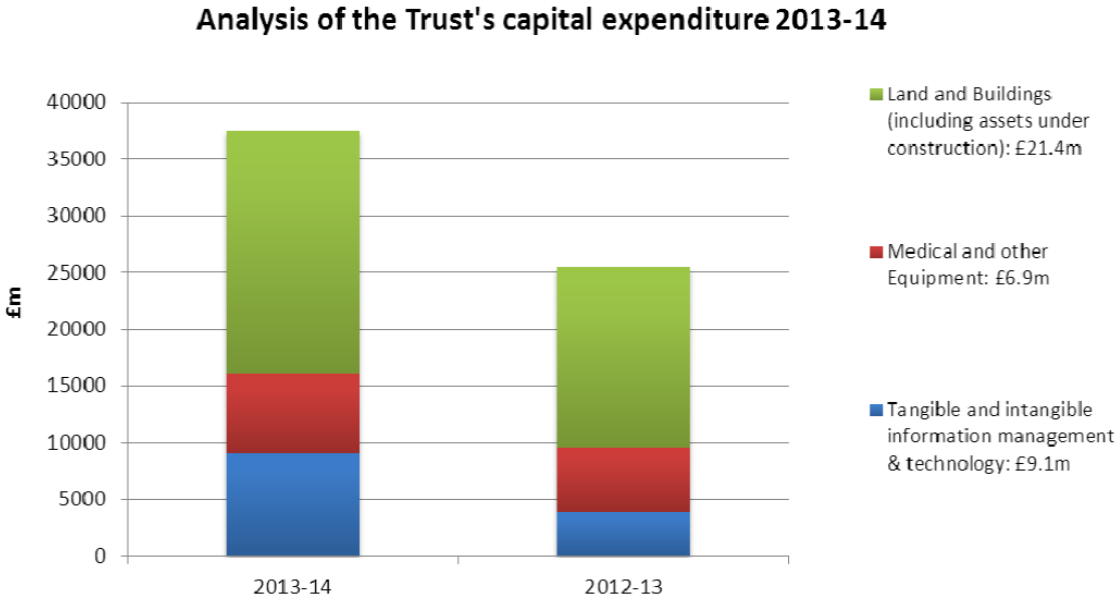


Figure 2.B Analysis of the Trust's Capital Expenditure 2013/14

▶ Balance sheet

The Trust planned to maintain cash holdings at more than £18m at the end of March 2013, which was achieved with an actual cash balance of £19.9m at the year-end. The debtors' position increased by £16.5m in 2012/13 and this includes several large debts outstanding with the local PCTs at the year-end, which were received in April 2013. The creditors' position has increased by £14.3m from the prior year. Managing

a similar change in both debtors and creditors has also enabled the cash position to be maintained.

2.5 The Leicester Royal Infirmary Site

Leicester Royal Infirmary (LRI) provides Leicestershire's only Emergency Department (ED) and is located on the southern edge of the city centre. The site is located on the A594 through Leicester providing easy access to main bus routes that serve the wider city and is also close to the train station. A hopper bus service is also available from the train station to the site and runs at regular intervals.

The LRI is the main acute site for UHL in Leicester with a current bed provision of 965 (October 2014). Services delivered from this site include:

- Trauma
- General Surgery
- Adult & Paediatric ED
- Acute Medicine
- Emergency Surgery
- Vascular Surgery
- Women's services including obstetrics & gynaecology (plus emergencies)
- Children's Services
- Central Pathology
- Infectious Disease
- Oncology & Radiotherapy

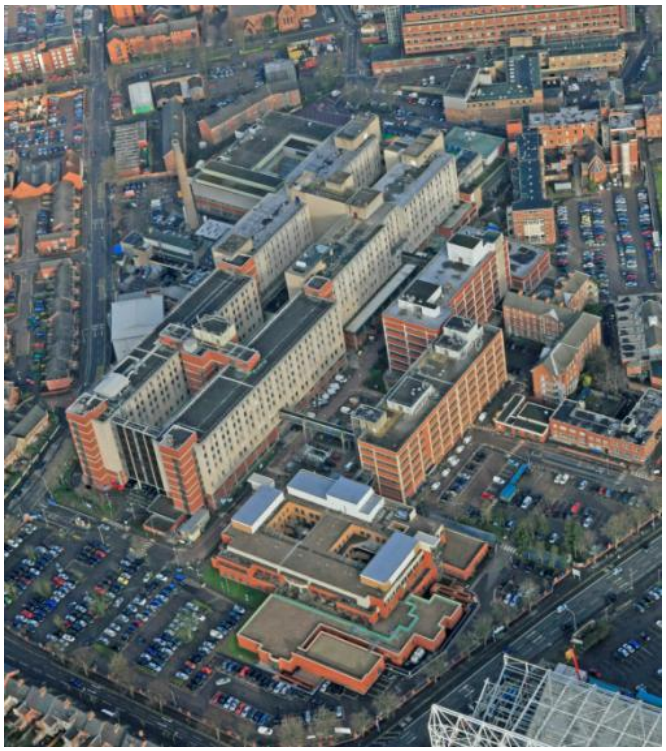


Figure 2.C Leicester Royal Infirmary Photo, Feb 2009

The buildings on site are varied, predominantly multi storey blocks; however there is a Grade II Listed Building. The site has expanded over time to meet increased demand and is in need of upgrading in parts.

The LRI site was condition surveyed in 2011 with 24% being categorised Condition B for the Physical Facet, denoting that it meets the current NHS standards; and 76% being classified Condition C denoting that major repair or replacement will be needed soon. However in 2013, the Condition B figure reduced to 13%, consequently the Condition C figure increased to 87%.

Figure 2.D Leicester Royal Infirmary Site Plan

2.5.1 Site Ownership

The land in the ownership of UHL at the LRI is highlighted below.

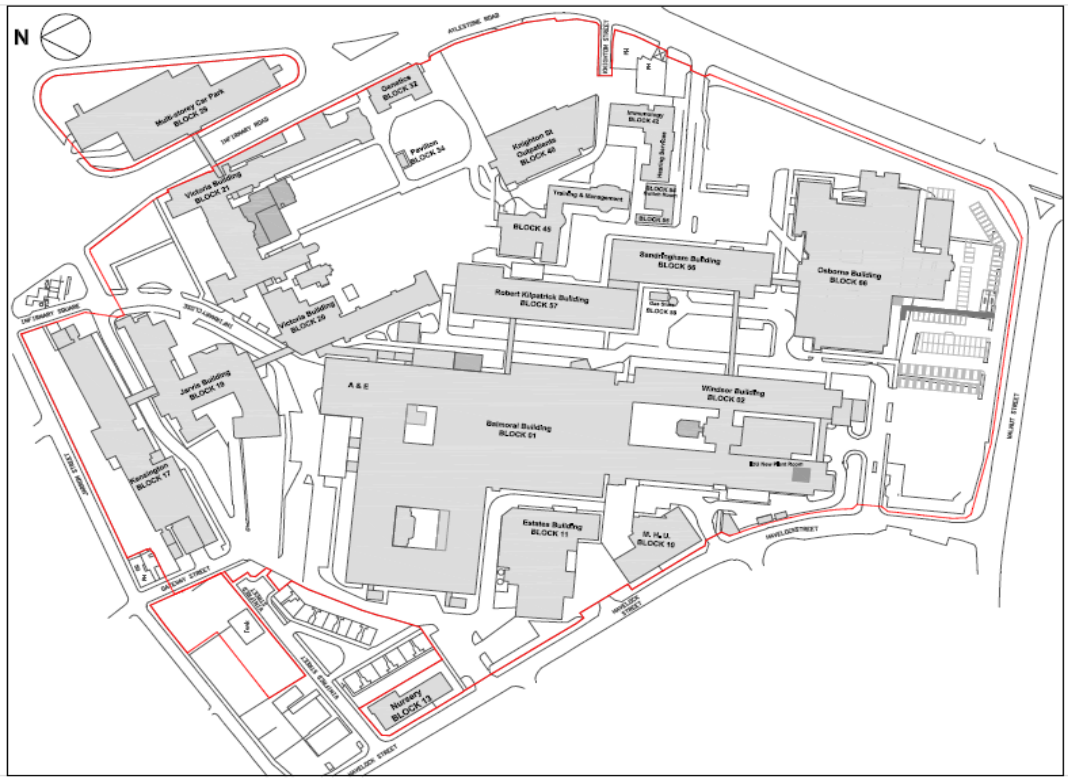


Figure 2.E UHL Land Ownership Plan: Leicester Royal Infirmary

2.6 Site Specific Constraints

The site is heavily occupied and access points for the proposed development will be constrained by the one way road system and layout of the site.

Options for construction are severely limited due to the highly developed nature of the site that is also land locked on all of its boundaries.

Any construction will take place on a fully operational site, and the sequencing and project timetable will be constrained by the need to maintain safe operations at all times.

2.7 Background to the Redevelopment Requirement for Emergency Care

Over the past 8 years there has been increasing concern within the Trust that the demands placed on emergency services exceed capacity. An indication of this problem is an increase in attendances to its ED of around 5% per annum (including the Urgent Care Centre (UCC)). This has resulted in many patients waiting for excessive periods; UHL's performance is frequently below the national standard of 95% of patients being seen, treated and discharged/ admitted in less than 4 hours. This manifests itself in reduced quality of care for patients, increased risk of harm, increased mortality, reduced clinical effectiveness, an unacceptable delay in treatment and compromised patient safety. In a similar fashion, emergency admissions to the Trust have been growing at around 3.5% per annum, creating similar pressures on medical assessment bed stock.

The Trust has updated its 5 Year Estates Strategy which aims to deliver a sustainable clinical services strategy underpinned by robust contractual and financial models which will deliver the right care in the right place; and with the best outcomes for the Trust's defined patient population. The strategy outlines a number of key capital projects to deliver its vision and the Emergency Floor development sits within this programme. In June 2013 a Strategic Outline Case for the Emergency Floor was submitted setting out the key strategic drivers and objectives for the proposed project. In November 2013 an Outline Business Case for the Emergency Floor was submitted; further work was then undertaken on this to align the case with the Better Care Together, resulting in a Developed OBC which was submitted in August 2014.

Previously, UHL has submitted its trajectory for improvement to the NHS Trust Development Authority (NTDA) which was agreed by the Trust Board as part of the Trust's Operating plan. Poor performance continues to result in significant financial penalties which impacts on the Trust's ability to deliver a financial balance.

Table 2.2 2013/14 and 2014/15 Penalties

National Penalties	13/14 FY (£)	14/15 M1-7 (£)	14/15 FOT (£)
ED 12 Hour Trolley Breaches	(6,000)	(2,000)	(3,429)
ED Wait Times (Automatic)	(294,198)	(532,200)	(912,200)
Total Automatic Penalties	**(300,198)**	**(534,200)**	**(915,629)**
Local Penalties	**Total (£)**	**Total (£)**	**Total (£)**
ED Wait Times RAP	Reinvested	(170,000)	(1,020,000)
Total Local Penalties	-	(170,000)	(1,020,000)
Total Local Penalties	**(300,198)**	**(704,200)**	**(1,935,629)**
Other Linked Penalties	**13/14 FY (£)**	**14/15 M1-7 (£)**	**14/15 FOT (£)**
Ambulance Turnaround	Reinvested	(2,015,000)	(3,454,286)
Total Automatic Penalties	**-**	**(2,015,000)**	**(3,454,286)**
Total Direct and Linked Penalties	**£(300,198)**	**£(2,719,200)**	**£(5,389,914)**

2.8 Existing Arrangements

The current ED and associated medical assessment areas were originally designed to serve annual attendances of approximately 100,000. In the full year 2013/14, there were 151,568 attendances to the ED (including Eye Casualty) and 59,218 attendances to the UCC, which is currently in a separate location. Adult emergency admissions at LRI are currently in the region of 24,000 per annum (excluding stroke and oncology which do not use the emergency department and associated facilities).

The reasons for the increased pressure on LRI's emergency services can be summarised as follows:

- The local community is an ageing population and there has been growth in the number of frail patients and those suffering from dementia, UTIs and D&V, demanding an increase in isolation facilities[4].
- GP capacity in the city is constrained and the situation will be further compounded by forthcoming retirements and the gap in trainee GPs.
- UHL's emergency services supports a population of approximately 1 million, making the LRI the largest emergency services department in the country
- There is no other ED within a 25 mile radius.

[4] University Hospitals of Leicester NHS Trust LRI Emergency Services Design Operational Policy 2013 (Appendix 2B)

- The way the out of hours service has developed across the community has increased pressure on ED.

There is an unusual double peak in daily activity between early afternoon and the evening; unlike other centres it is unique in that the second peak is higher than the first with the highest attendances between 6pm and 10pm. At any one hour of the day, there may be between 1 to 16 attendances in any area of the department. There can be at least 40 patients attending the department per hour for 3 or more hours at a time. The full year 2013/14 4 hour figure for UHL, including the Urgent Care Centre (UCC), was 88.39% of attendances. The 2014/15 year to date (at month 7) 4 hour figure was 89.58% of attendances.

2.8.1 Improvement Plans

In response to a consistent underachievement of the 4 hour target, new clinical roles were introduced and a new pathway commenced in November 2011 called 'Right Place, Right Time'. This initially resulted in a considerable improvement in the Trust's emergency performance. However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency admissions 7% higher in the final quarter 2012/13 compared to the same period last year) achievement of the 4 hour target deteriorated (week ending 3rd November and 10th November 2013 it was 87.8% and 90.2% respectively)[5].

The Emergency Care Action Team (ECAT) was set up by the Trust in April 2013 in response to a number of challenges in the delivery of the emergency care pathway, resulting in an ongoing 4 hour target underachievement. ECAT has more recently been superseded by the Emergency Quality Steering Group. Through these groups a number of strategies have been implemented via the development of Action Plans (Appendix 2D) that focus on improving ED performance and patient experience via operational improvements and investing in a capital project to develop an Emergency Floor solution. Most recent work has centred on patient flow and management of the patient journey with key work-streams looking at front door processes, back door processes (discharge), frailty pathways and resolving organisational issues.

2.8.2 Process Review

It has been recognised that UHL's emergency care pathway is in need of modernising and improvement and in a drive to implement such change, Dr Ian Sturgess was recently appointed by the wider health economy. Dr Sturgess has undertaken a robust review and redesign of associated clinical process and procedures over a six month period; the objective being a radical improvement in UHL's emergency care performance.

The review has understood current patient flow and management of the patient journey in its entirety for the emergency care pathway.

Observations have been made from the perspective of the patient, being driven by the four questions patients should be able to answer soon after arrival/ admission, namely:

[5] UHL NHS Trust Emergency Care 4hour Performance Trajectory 2013 – Refer to Appendix 2C

- **What is wrong with me or what are you trying to find out?** This is achieved by timely competent assessment by a decision making clinician who discusses and explains their findings with the patient.
- **What is going to happen now, today and tomorrow?** This is achieved by the construction of an end to end case management plan by a senior clinical decision maker in partnership with the patient who ensures that these 'inputs' occur in a timely manner.
- **What do I need to achieve to leave hospital?** This is achieved by setting individualised patient focussed clinical criteria for discharge whilst maintaining timely monitoring of the progress of the patient and ensuring early intervention if there is any negative deviation from the expected recovery pathway. The aim is to create expectation akin to that seen with the 'enhanced recovery programme' in elective care.
- **When am I going home?** This is achieved by setting the expected date of discharge which does not include the unnecessary waits known within the system. For admitted patients, assertive board rounding and one stop ward rounds ensure that all tasks are completed on time and that as little as possible of the patient's time is wasted waiting for the necessary inputs to occur. Unnecessary waits are highlighted and managed within the team and if not these waits are escalated.

The review identified three things that are amenable to change:

- **Structure:** structural change alone rarely delivers any actual benefit
- **Process:** optimising processes focusing on what adds value to the patient is the main element of any improvement programme
- **Patterns:** relationships, behaviours, motivation, peer to peer support and challenge. This is a crucial element to deliver sustainable improvement. Top down enforced process changes will never sustain, whilst bringing about a desire to see improvement in a collegiate atmosphere drives sustainable improvement.

The actions from the review are currently being implemented through the Emergency Quality Steering Group.

Dr Ian Sturgess was involved with the detailed design process for the proposed Emergency Floor development which included confirm and challenge sessions with the clinicians from each aspect of the proposed development, around the revised models of care, schedules of accommodation and associated design.

2.8.3 Existing Workforce

Whilst there has been a successful recruitment drive at LRI for all levels of staff, the unit has historically been short-staffed and dependent on the non contracted workforce which is both less efficient and provided at a higher hourly rate. The poor environment and inefficiency in process have also been contributory factors in recruiting new staff and retaining the existing workforce. These issues are contributing factors to the worsening financial performance. Since proposals have been published relating to the new Emergency Floor Development, the Trust's ability to recruit and attract has improved with a current qualified nursing vacancy position of 12%.

2.8.4 Existing Accommodation

The space, adjacencies and quality of accommodation provided for emergency care at LRI is unsuitable and does not comply with current national guidelines. The following outlines the current status:

- **Access**: Patients currently experience a poor patient journey when accessing emergency care and UCC departments. There is a physical separation of front door access creating a booking in and assessment process within the UCC and then a further booking process at the ED when a patient is redirected there
- **Paediatrics**: UHL needs to meet the NSF for Children and Young People standards[6] relating to separate entry, discrete space and child friendly environment. In addition UHL requires a single integrated Children's Hospital in order to meet congenital heart standards; of which this will be a part. The department currently has limited cubicles that do not meet the need of current attendances
- **Majors**: Currently there are 16 adult Majors spaces. The provision does not meet demand with the following consequential issues:
  - Patient safety is compromised with severely non-compliant space around the bed for access to the patient
  - Doubling up of cubicles with chairs to house more than one patient at a time.
  - The corridors leading out of majors are continuously blocked by patients in trolleys or chairs in an attempt to meet capacity
  - Privacy and dignity for patients is severely compromised
  - Compliance with infection control standards is compromised by limited space
  - Patient satisfaction is challenged, as is any opportunity for a sustainable enhancement of the patient experience
  - Cubicle space to accommodate incoming ambulance arrivals is insufficient, contributing to the current delays with ambulance handovers into the unit
- **Resuscitation**: There are 7 bays (the 7th bay was opened in summer 2014) and each are significantly undersized with non compliant space around the bed for service delivery
- **Minors**: These are significantly undersized compromising patient flows with the overall numbers slightly underprovided. It is important to note that 'minors' attendances at LRI 'minors' tend to be of a higher acuity (fractures/ significant soft tissue injuries) than the nearby walk in centres at Loughborough (x1) or Leicester City Centre (x2). This is due to patients with lower acuity minor injuries choosing to be seen at those centres (approx 150,000 between those three walk in centres), leaving the higher acuity work being treated at LRI ED
- **Imaging**: There is currently no dedicated emergency imaging suite; patients are required to attend the main imaging department (which is 45-60m away) reducing efficiencies and patient experience and safety

6 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/199952/National_Service_Framework_for_Children_Young_People_and_Maternity_Services_-_Core_Standards.pdf

- **Mental Health**: There is a need to meet requirements relating to a dedicated area that can be secured off from the rest of the department. Section 136 requirements need consideration.
- **Emergency Decision Unit (EDU)**: The number of patient spaces provided is half the number required.
- **Elderly Frail Unit (EFU)**: The number of patient spaces provided is half the number required.
- **Medical Assessment**: There is an essential need to provide a triage and assessment service adjacent to the Emergency Floor for GP referred patients; to enhance patient flows through the department, and improve working relationships, processes and clinical effectiveness. Medical assessment beds are currently provided on 5th floor of the Balmoral Building

The ED current capacity provision is summarised in table 2.3 below:

Table 2.3 Current Capacity Provision

Name	Service	Capacity
Majors	Patients with potentially serious conditions or are too unwell to be able to walk without help. Most patients in this area will have been brought in by ambulance.	16 spaces (plus 12 chairs in doubled up cubicles
Minors and UCC	Less serious illnesses or injuries and functions similar to an NHS Walk-In Centre or Minor Injuries Unit. Patients will be assessed and treated by Emergency Nurse Practitioners, physiotherapy practitioner and ED doctors. The ED review clinic, in which patients with certain soft tissue injuries are reassessed, is held in this space 3 times per week.	21 spaces
Resuscitation	This area for specialist equipment and space for patients with life-threatening illnesses, such as heart attacks or severe breathing problems, as well as major injuries.	7 spaces
Paediatrics	Emergency services for children and young people under the age of 16. Cared for by specially trained staff. Unwell or severely injured children are treated in the main resuscitation room.	12 spaces
Ophthalmology	Eye emergency services (currently located at Level 1 Windsor).	4 spaces

2.8.5 Trust's Risk Register

There are currently three extreme/high level risks (RAG rated 25, 20 and 16 pre mitigation), and four moderate level risks (RAG rated 12, 12, 10 and 8 pre mitigation)

related to the ED on the Trust's Risk Register. Details of these can be found in Appendix 2E and Appendix 2F.

2.9 Strategy

This business case, and the associated corporate and project objectives, are supported by a number of significant strategic documents and programmes. This section provides an overview of the driving policies and guidance documents at National, Regional and Local level that can provide context and support the case for change in relation to increasing capacity and providing modern, accessible emergency services. These range from national and local strategies and programmes, to national and local standards and guidance.

2.9.1 National Strategies, Programmes and Guidance

The National programmes and guiding policies are summarised below. A more detailed summary with references can be found in Appendix 2G.

Table 2.4 National Strategies, Programmes and Guidance

NATIONAL	
Health and Social Care Act 2012[7]	The government's Health and Social Care Bill outlines the future commissioning arrangements across the NHS
Department of Health Emergency Department Clinical Quality Indicators[8]	The Revisions to the NHS Operating Framework for 2010/ 11 signalled the intention to replace the 4 hour waiting time standard for EDs with more clinically relevant indicators. The clinical quality indicators for the ED have been designed to present a comprehensive and balanced view of the care, and accurately reflect the experience and safety of patients and the effectiveness of the care they receive. These indicators support patient and public expectations of high quality emergency services and allow EDs to demonstrate their ambition to deliver consistently excellent services which continuously improve.
Care Quality Commission[9]	The Care Quality Commission (CQC) implemented 5 domains of quality care[10] to assess provision of care against. These domains are defined as Safety, Effectiveness, Caring, and Responsive to people's needs and well led organisation. In addition the CQC have recently implemented an intelligent monitoring approach to give inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust.

[7] http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[8] https://www.gov.uk/government/news/accident-and-emergency-provisional-quality-indicators

[9] http://www.cqc.org.uk/public/about-us/our-inspections/our-new-acute-hospital-inspection-model

[10] http://www.cqc.org.uk/sites/default/files/media/documents/20130503_cqc_strategy_2013_final_cm_tagged.pdf

<table>
<tr><th colspan="2">NATIONAL</th></tr>
<tr><td>NHS Operating Framework[11]</td><td>“Everyone Counts: Planning for Patients 2014/15 to 2018/19 sets out the business and planning arrangements for the NHS. It sets out five high level outcome domains that the NHS should be aiming to improve (below).This business case delivers improvements against each domain:<table><tr><td>Domain 1</td><td>Preventing people from dying prematurely</td></tr><tr><td>Domain 2</td><td>Enhancing quality of life for people with long-term conditions</td></tr><tr><td>Domain 3</td><td>Helping people to recover from episodes of ill health or following injury</td></tr><tr><td>Domain 4</td><td>Ensuring that people have a positive experience of care; and</td></tr><tr><td>Domain 5</td><td>Treating and caring for people in a safe environment; and protecting them from avoidable harm</td></tr></table></td></tr>
<tr><td>Quality, Innovation, Productivity and Prevention (QIPP)[12]</td><td>Within the national context of no significant growth in the NHS forecast, and a requirement to save £20bn by 2015, the Quality, Innovation, Productivity and Prevention (QIPP) is a national initiative looking to provide an integrated, systematic approach to large-scale change. Within this all NHS organisations are encouraged to make better use of existing resources and teams to deliver service improvements.</td></tr>
<tr><td>Transforming Urgent and Emergency Care Services in England: Urgent and Emergency Care Review, End of Phase 1 Report, High Quality Care For All, Now and for Future Generations, NHS England November 2013[13]</td><td>NHS England has completed phase one of their review of urgent and emergency care in England, which proposes a fundamental shift in how urgent care and emergency services are delivered. It aims to introduce two levels of hospital based emergency centre with specialist services in larger units The report highlights the need for. It the importance of emergency services being able to provide access to the very best care for the most seriously ill and injured patients, 24 hours a day and 7 days a week. The review highlights five key elements to ensure success of implementing the reviews proposal of a two tiered emergency centres.

More information on the Phase 1 Report can be found in Section 2.9.2 below.</td></tr>
<tr><td>NHS 5 Year Forward View[14]</td><td>The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how it can be achieved. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. These are likely to include more integrated hospital care, extended primary care, concentration of elective care, urgent/emergency care networks, and greater use of technology.</td></tr>
<tr><td>High Quality Care for</td><td>NHS England has implemented an initiative that focuses on high</td></tr>
</table>

[11] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

[12] https://www.evidence.nhs.uk/qipp

[13] http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf

[14] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NATIONAL	
All, now and for Future Generations: Transforming Urgent and Emergency Care Services in England June 2013[15]	quality care for all, now and for future generations. This initiative focuses on how emergency services can deliver the best outcomes for patients and the community in the future
Future Hospital: Caring for Medical Patients, Royal College of Physicians (Sept 2013)[16]	The Royal College of Physicians established the Future Hospital Commission, an independent group tasked with identifying how hospital services can adapt to meet the needs of patients, now and in the future. Its report, Future Hospital: Caring for Medical Patients sets out their vision and recommendations.
HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)[17]	HBN 15-01 provides guidance on design considerations for the built environment in ED areas. These areas include designated clinical spaces such as minors, majors, resuscitation, mental health, children's and adult spaces and other hospital locations that are key to adjacency requirements, as well as the support facilities that underpin these areas. The guidance outlines the emerging principles in planning facilities for emergency care people such as user requirements and their views, location and departmental factors.
Royal College of Paediatric and Child Health 'Standards for children and young people in emergency care settings' [third edition] 2012[18]	This guidance document replaces the 'Red book' guidance and sets out the minimum standard requirements for how children in emergency settings should be treated - covering areas from service design and environment to staff training and safeguarding. It also contains specific standards against which healthcare providers can be measured.
The Silver book – National Guidance 'Quality Care For Older People With Urgent and Emergency Care Needs, June 2012[19]	This national guidance document addresses the care for older people during the first 24 hours of an urgent care episode. It outlines the urgent care needs of older people and the competencies required to meet these needs. It states that the older person's care needs must be delivered within the first 24 hours and as part of a whole systems strategy. This document outlines current clinical guidance and suggested standards.
Guidance for commissioning integrated URGENT & EMERGENCY CARE - A 'whole system'	This guidance document focuses on the interdependencies between services. It describes what urgent and emergency care is, why it is important to commissioners, and the need have a holistic system in terms of commissioning urgent and emergency care. It provides guidance on how to ensure integrated 24-hour urgent and emergency care focussing on consistency, quality, safety and improved patient

[15] http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

[16] https://www.rcplondon.ac.uk/sites/default/files/future-hospital-commission-report_0.pdf

[17] HBN 15-01 Planning and Design Guidance: Accident and Emergency Departments (April 2013)

[18] www.rcpch.ac.uk/system/files/protected/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf

[19] www2.le.ac.uk/departments/cardiovascularsciences/people/conroy/docs/SILVER_BOOK_FINAL.pdf

NATIONAL	
approach, July 2013[20]	experience. How patient pathways can be streamlined.

2.9.2 Transforming Urgent & Emergency Care Services in England: Urgent & Emergency Care Review, End of Phase 1 Report - Potential Impact on UHL

The recent publication of NHS England's (November 2013) end of Phase 1 Report relating to transforming urgent and emergency care across England is particularly relevant to this section and therefore is summarised separately in this section of the OBC.

Hospital EDs are set to be reclassified, with between 40 and 70 offering a higher level of staffing and expertise. Sir Bruce Keogh has proposed that existing Emergency Departments are designated as either "Emergency Centres" or "Major Emergency Centres" − although these titles could change.

Major Emergency Centres will be large units and will provide a range of highly specialised services delivering the very best outcomes for patients. Specifically noted is the ability to treat heart attacks and stroke patients.

In accordance with the above, UHL is likely to be designated a "Major Emergency Centre", with the LRI supporting the Emergency Floor and Glenfield Hospital providing highly specialised cardiac care. Work will need to be undertaken to understand how much additional work this may bring to LRI from neighbouring hospitals rebadged as "Emergency Centres". Since the closest ED is approximately 25 miles away, it is possible the LRI already deals with much of this work. However, this will need to be tested when there is a better understanding of how services are to be configured locally.

There is a recommendation for the ED and Urgent Care Centre to be collocated when it comes to delivering emergency services, which has been clinically modelled as part of the proposed LRI Emergency Floor development. However, there will be renewed impetus to avoid patients coming to the LRI site in the first place. On balance there are likely to be two changes to the acuity of presentations at the LRI:

- An outward shift of less acute care
- An inward shift of more complex care

Work will need to be undertaken to understand the overall impact of these factors. The focus of the Health Care Planners and associated Emergency Floor Project Team has always been to provide generic flexible accommodation, which can respond to changing shifts in acuity, workload and case mix. The design solution needs to ensure that this is delivered and that facilities remain as generic as possible to deal with changing demand.

[20] http://www.rcgp.org.uk/news/2013/july/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

The second phase of the review will now look at the issues in more detail. It is unclear when it will report.

2.9.3 Regional Strategy/ Guidance

Locally a strategic Five Year Plan and a Strategic Outline Case for Leicester, Leicestershire and Rutland Health & Care Community has been developed and is currently going through respective Boards for approval purposes. It sets out the medium term direction for the models of health, care and support services that will need to be in place in five years time across Leicester, Leicestershire and Rutland (LLR represents the 'unit of planning') and the steps needed to realise that vision. The focus of the strategy is on those areas that have the greatest potential to deliver significant improvement in outcomes over the next five years. For UHL, the LLR Five Year Plan provides the framework within which our major business cases will be set and considered.

The strategic plan signals a move away from incremental, organisational specific improvement to a longer-term view and system wide intervention to support transformational change. In doing so, it will set out a roadmap to better outcomes for citizens.

The LLR plan and SOC provides the framework within which each statutory NHS organisation (the three CCGs, UHL, Leicestershire Partnership Trust (LPT) and NHS England) and local authority partners will develop their own plans. These will detail how they will deliver on the component parts for which they are responsible.

The plan will be adopted by the three LLR Health and Wellbeing Boards and will incorporate the respective Better Care Fund plans to improve re-ablement and service integration between primary and social care.

Recently two national documents (NHS England Five Year Forward View and the Dalton Review) were published. They lay out alternative organisational forms with the intention of driving integration and supporting/enhancing the future sustainability of provider organisations. Examples include Multispecialty Community Providers, Primary and Acute Care Systems (PACS) and a Specialised Service provider alliance. This creates a real opportunity to complement the plans in place and remove unnecessary barriers to change.

CCG Out of Hospital Strategies

There are three LLR CCGs across Leicester: all three have agreed to commission major provider contracts collaboratively. The three CCGs are:

- Leicester City
- West Leicestershire
- East Leicestershire & Rutland

When developing commissioning plans, the following goals were agreed:

- To improve health outcomes
- To improve the quality of healthcare services
- To use our resources wisely

The key transformation programmes developed were:

- Proactive Care
- Emergency and Urgent Care
- Capacity and capability in Primary Care
- Community Hospitals: The way forward

Joint Strategic Needs Assessment (JSNA)

The development of a Joint Strategic Needs Assessment (JSNA) is a statutory requirement that is placed upon the Directors of Public Health, Adult and Children's Services in all boroughs to guide the commissioning of heath, well-being and social care services within local authority areas as part of the Health & Social Care Act (2012).The JSNA provides a systematic method for reviewing the health and well-being needs of a population, taking account of those groups or individuals whose needs are not being met, who are experiencing poor outcomes, or for whom special arrangements may be necessary. It aims to understand both short-term needs (three to five years) and long-term needs (five to ten years) and service requirements for patients in a given population.

The JSNA for Leicester (2012) states that: "People in the city die early, particularly from circulatory diseases, cancers and respiratory disease. Poor health is largely driven by deprivation and exacerbated by lifestyle factors embedded within communities. The inequalities gap in health between Leicester and England is not narrowing and the gap between the more deprived and the more affluent communities within Leicester has remained a stubborn inequality. We want to improve the health and wellbeing of the poorest fastest." This re-emphasises the importance of the JSNA as the starting point for strategy development and commissioning decisions.

Emergency Care Network

The Leicester, Leicestershire & Rutland (LLR) Emergency Care Network (ECN) role is to put in place measures to improve urgent care across LLR. Outlined below are some of the key initiatives the network is implementing:

- **Emergency Response:** specialised services in fewer hospitals (Emergency Department, specialised services such as trauma, stroke, primary angioplasty, vascular/ emergency surgery, and emergency ambulance service). These ED centres will be operational 24/7 with full and continuous cover.
- **Urgent Care System:** a key priority for improving urgent care is to improve patient flows across the whole system with all agencies involved in delivering urgent care working effectively together. This is governed by the LLR Emergency Care Network, which is chaired by Leicester City CCG on behalf of the local health and social care community. An integrated approach utilising reworked Urgent Care criteria such as agreed range of urgent care services (cuts, stings, etc), alcohol and substance misuse, crisis resolution, (mental health and social care), see & treat and hear & treat.
- **Integrated Health & Social Care System:** consistent standards, shared protocols, timely flow, integrated workforce, training and education, care networks. Access will be determined by local demand.

- **NHS 111:** in Sept 2013 the Trust became part of the LLR-wide NHS 111 programme, a new service introduced to make it easier for patients to access local NHS healthcare services when they need medical help fast but it is not a 999 emergency. Demand on UHL's emergency services is anticipated to further increase as a result of the new NHS 111 service being introduced. The service has been launched in other areas of the country already and early indications point to increased attendance rates at EDs as a result.
- **East Midlands Ambulance Service (EMAS) Local Response:** building on a successful pilot, the CCG continues to work closely with EMAS to deflect and reduce inappropriate secondary care activity. This will be achieved by an innovative pathway to keep patients within the care of general practice, where is it is safe and appropriate to do so, thereby avoiding an unnecessary journey to hospital.

2.9.4 Local Strategy

Nationally, if the NHS continues with current operating models and fails to make any further productivity improvements, it will be facing a funding gap between projected spending requirements and resources available of around £30bn by 2020/21. This challenging economic climate means that for the foreseeable future local NHS commissioners are unlikely to receive 'growth' funding in line with historical levels. Whilst health budgets are ring fenced and CCGs can expect to receive modest growth in capitation funding, local authorities are already experiencing and will continue to face significant real terms cuts to funding received from central government.

The local health and social care system is already facing financial pressures – the health economy is one of 11 "challenged" economies identified by NHS England due to broad performance challenges together with little evidence of collaborative planning and delivery to date.

Since formation in 2000, UHL has narrowly broken even every year with the exception of 2013/14 when it posted a £39.7m deficit. UHL plans for the short and medium term are to address both the financial deficit and problems with operational performance – discussed earlier - without detriment to outcomes.

Changing Population

Leicester, Leicestershire and Rutland (LLR) has a population of 1.03 million. Around one third live in the city, with two thirds in the counties. In terms of ethnicity, the City of Leicester is much more diverse than the county areas, and the ethnic diversity is increasing. Service design and delivery must take in to account this diversity; particularly in terms of access to services.

The overall population is forecast to grow by around 32,000 (3%) by 2019. This represents a rate of growth slightly lower than that for England as a whole. The City of Leicester has a younger population, with the county areas markedly older. This difference will continue to 2019, with the city having a markedly larger proportion of younger adults and a smaller proportion of older people.

The population profile of Leicester City reflects the fact that compared with the county areas, people in the city die earlier, particularly from circulatory diseases, cancers and respiratory disease. Poor health is driven by deprivation and exacerbated by lifestyle

factors. Leicester is ranked 25th worst out of 326 local authority areas in England on the national Index of Deprivation (2010). Health inequalities within Leicester and compared to England as a whole have proved enduring. There are also areas of deprivation outside the city – notably certain wards of North West Leicestershire.

Though there are clear demographic differences across LLR, in general the next 20 years is forecast to see an increasingly ageing population, particularly in the county areas. Of the total population growth of 32,000 to 2019, 22,000 will be in the over-65 group. This is largely a challenge in the county areas. By contrast, the key challenge in Leicester City will continue to be premature preventable death and disability.

As people grow older, there is a higher prevalence of long term illness and disability. The number of people living with long term conditions will grow as the population ages. Furthermore, many people will have multiple conditions, meaning their care needs are more complex. From a health need perspective there is a marked variation in life expectancy across LLR. Any plans for service improvement must respond to these challenges and make a significant contribution towards better outcomes. This Business Case recognises the challenge and enhances the future service provision targeting an integrated emergency service across the health economy.

Better Care Together: A Blueprint for Health & Social Care in LLR 2014 - 2019

For Leicester, Leicestershire and Rutland (LLR) a Long Term System Model (the "Model") has been constructed to articulate what would happen when faced with the challenges described in the "A Call to Action" (published by NHS England). If no action were to be taken to improve the quality, outcomes and value for money of services currently provided to patients, or to develop new services, then the model predicts a financial gap over the next five years that rises to £398m by 2018/19.

In response, the Better Care Together (BCT) programme represents the biggest ever review of health and social care across Leicester, Leicestershire & Rutland (LLR). The programme represents a partnership of NHS organisations and local authorities across LLR, working together to achieve major transformation in the current and future delivery of services that are of the highest quality and are capable of meeting the future needs of local communities.

The programme is underpinned by a clear case for change with the aim of focusing on a significant increase in community based prevention and care and delivering only the most complex care from an acute hospital setting. As a consequence of the shift to community settings the Trust intends to consolidate acute services onto a smaller footprint and to grow its specialised, teaching and research portfolio; only providing in hospital the acute care that cannot be provided in the community. In doing this the Trust expects to significantly increase the efficiency, quality and, ultimately, the sustainability of key services; shrink the size of the required estate; significantly rebalance bed capacity between acute and community settings; provide alternative solutions to traditional in-patient care and thus reduce total costs. The impact of this on UHL could include:

- Delivering better care to fewer patients
- Making more of our specialist expertise available to primary and social care and delivering more of our non-specialist services to the community
- Play a much bigger role in preventing illness and supporting patients before they reach a point of crisis

- A greater focus on specialised care, teaching and research
- Redevelopment of the Emergency Department at the LRI
- Significantly smaller acute hospitals overall
- Fewer acute hospital beds
- Concentrating acute services on two sites rather than three
- Reshaping services on the Leicester General Hospital site including community beds and the Diabetes Centre of Excellence.
- Financially sustainable

The BCT case for change is summarised in the diagram below:

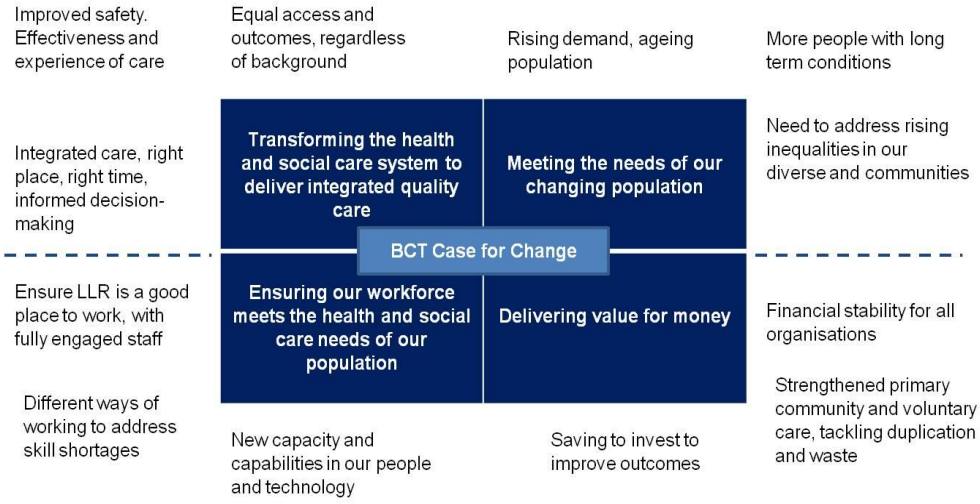


Figure 2.F Better Care Together Case for Change

LLR Health Community Estate

Over the last two and a half years the LLR Health Community has worked together to better understand the collective capacity and estate challenge facing local organisations. Informed by jointly commissioned analysis, the local health community has committed to a strategy to simplify, standardise and share the delivery of core Estates/ FM services and to work together in reducing the collective asset base, better utilise the residual space and capacity footprint and improve the quality of the physical environment.

2.9.5 Trust Vision

In the next five years, UHL will become a Trust that is internationally renowned for placing quality, safety and innovation at the centre of service provision. The Trust will build on its strengths in specialised services, research and teaching; offer faster access to high quality care, develop our staff and improve patient experience. The Trust calls this ‘Caring at its Best’.

The Trust recognises the challenges facing the organisation and the LLR health and social care system which are the consequence of significant internal and external challenges which include:

- The financial pressures facing public sector organisations
- Rigorous regulation of healthcare providers
- Changes in the wider health and political landscape
- Focus on choice and greater patient and community involvement
- Inherent inefficiency of current configuration
- Fiscal drag of aging estate reflecting incremental development

2.9.6 Trust Strategic Objectives

Underpinning the vision and purpose are the strategic objectives of the Trust, these are:

- High quality care for all – patient safety, improve outcomes & patient experience
- Quality Commitment – save lives, reduce harm, patient centred care
- 7 day a week consultant delivered services
- Optimising clinical service adjacencies to reduce avoidable deaths
- Reducing time patients avoidably spend in hospital
- Care closer to home through better integration with Community services
- Providing high quality services in a financially affordable & sustainable way
- Understand potential impact of alliances of care at local, regional & national levels

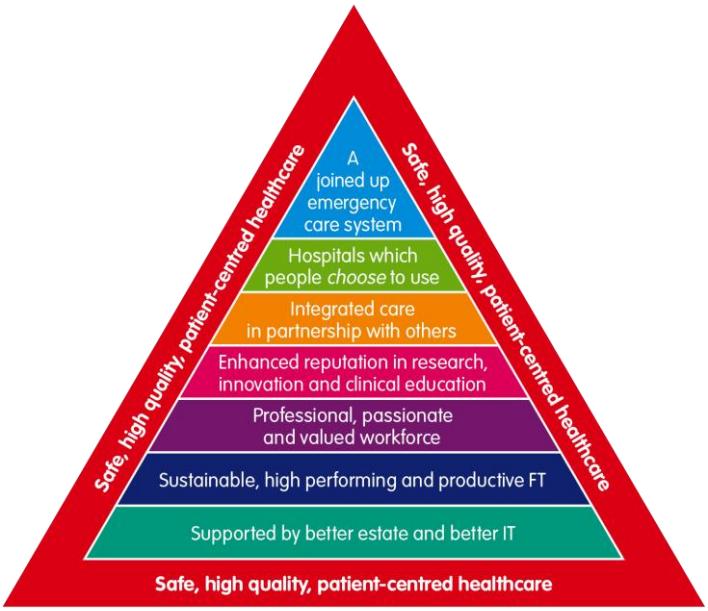


Figure 2.G Trust Strategic Objectives

By delivering the strategic vision the Trust will fulfil the purpose of providing ‘Caring at its Best’.

Caring at its Best

The UHL team is made up of more than 10,000 staff providing a range of services primarily for the one million residents of Leicester, Leicestershire and Rutland. The nationally and internationally-renowned specialist treatment and services in cardio-respiratory diseases, cancer and renal disorders reach a further two to three million patients from the rest of the country.

UHL work with partners at the University of Leicester and De Montfort University providing world-class teaching to nurture and develop the next generation of doctors, nurses and other healthcare professionals, many of whom go on to spend their working lives with the Trust.

The Trust focuses on being at the forefront of many research programmes and new surgical procedures, in areas such as diabetes, genetics, cancer and cardio-respiratory diseases. UHL is now the home of three National Institute of Health Research (NIHR) Biomedical Research Units and during the year carried out over 800 clinical trials, bringing further benefits to thousands of patients.

The heart centre at the Glenfield Hospital continues to lead the way in developing new and innovative research and techniques, such as surgery with a Robotic Arm, TAVI (Trans-Catheter Aortic Valve Insertion) and the use of the suture-less valves in heart surgery. UHL also have one of the best vascular services nationally, with more patients surviving longer after following an aneurysm repair (to fix a life threatening bulge in a blood vessel).

The Trust is proud to have some of the lowest rates of hospital-acquired infections, such as C. Difficile and MRSA, in the country; the hospital standardised mortality rates are very good, demonstrating a high clinical quality; with the provision of food also been rated as ‘excellent’ by an independent panel.

UHL’s purpose is to provide ‘Caring at its Best’ and staff have helped to create a set of values, which are:

- Focus on what matters most
- Treat others how we would like to be treated
- Be passionate and creative
- Deliver what is promised
- Be one team and be best when working together

UHL patients are at the heart of all that is done at the Trust. ‘Caring at its Best’ is not just about the treatments and services provided but about giving patients the best possible experience.

Each element of the objectives and supporting strategy are performance managed through the Trust Board scorecard, regularly reported to Board through the Integrated Performance Report (IPR).

2.9.7 Clinical Strategy

The Trust's clinical strategy (which can be found in its entirety at Appendix 2H) is focused on delivering high-quality, patient centred services in the most appropriate setting with excellent clinical outcomes. There will be a process of continual quality improvement for clinical outcomes, morbidity and mortality rates and other clinical indicators to ensure that the Trust remain the provider of choice for patients.

The Trust will implement an integrated Clinical Model for Unscheduled and Emergency Care in partnership with agencies across the Health and Social Care community - a model that will extend beyond the physical walls or buildings of the hospitals in Leicester. Patient pathways will be changed to ensure that patients are seen in the right place, at the right time by the right professional. Clinical models will be based on a mutually agreed understanding of how patients should flow through the system including who is responsible for particular aspects of a patient's care.

This clinical model will extend to out of hospital care. At one end of the spectrum, this will be supported through the development and implementation of mobile trauma expertise which will work in partnership with the Air Ambulance to fly to those most severely injured in accidents, to stabilise them and transfer them to the most appropriate centre within the 'golden hour' for their on-going treatment. In addition, the model will be supported by the development of new roles including extending roles of nursing and other professionals and offering creative recruitment strategies to meet the skill mix requirements.

A key component of the Trust's clinical strategy is the investment in a new "Emergency Floor" at the Leicester Royal Infirmary with new models of care by 2015/6 and will actively seek opportunities to become a stakeholder in the management of minor injuries units and the urgent care centre. This will create the optimum environment for patients who require care in an acute hospital setting ensuring patients get the appropriate intervention from the right clinician at the right time and in the right place. Emergency Department resources will be focused on the treatment of those patients with major illness and trauma, whilst admission for those with minor illness and injury will, where clinically appropriate, be avoided.

The Trust will actively promote access to out of hospital ambulatory care services and work in partnership to further develop pathways to prevent the need for hospital admission. Better long term condition management delivered in an integrated manner will mean that patients who have historically been admitted due to an exacerbation of their condition will be able to be safely managed in their own home under the care of their GP, in partnership with hospital services.

In particular the Trust will:

- Relocate the general surgical emergency take from the LGH to the LRI - this will improve the emergency pathway patient experience for general surgical patients and allow development of 7 day a week consultant delivered surgical triage meaning that general surgical patients will be seen and assessed more quickly by senior decision makers. Additional theatre sessions will be provided at the Leicester Royal Infirmary to accommodate the increase in demand from emergency surgical services on a single site.
- Promote centres of excellence such as the Elderly Frailty Unit (EFU) through the expansion of the Emergency Decisions Unit (EDU) and EFU at the Leicester Royal Infirmary.

- Expand imaging, pathology therapy and pharmacy services, to meet increased demand and provide a 24/7 service which minimise internal waits and improve the efficiency of the flow of emergency patients through the system.
- Continue to develop of our speciality take in the Clinical Decisions Unit (CDU) and Coronary Care Unit (CCU) at Glenfield as the "Cardiorespiratory Acute Floor" to ensure streamed patients receive timely care in the most appropriate setting.
- Relocate acute renal and transplant services to the Glenfield Hospital recognising the key interdependency between this service and cardiology
- Ensure that UHL has the right number and location of Augmented and Critical Care beds (level 1-3) with supporting staff both now and in the future to match changing patient demographics and models of care. Over the next five years, the Trust expects to treat more patients with increasingly complex conditions and this will result in an increased demand for Critical and Augmented Care beds. This is likely to require changes to the current 3-site Critical Care model to an integrated Critical Care service across 2 acute sites. This will enable UHL to retain Intensive Care training accreditation, recruit and retain staff, as well as respond to changing demands for the service.
- Ensure that University Hospitals of Leicester retains its status as a lead provider nationally and internationally recognised for its ECMO services. We will develop ECMO as a key part of an integrated advanced respiratory support service for adults with serious respiratory failure.

To facilitate these changes, where possible, the Trust will look to move our outpatient and non-complex elective services from the Leicester Royal Infirmary to a more appropriate and clinical setting which provides optimum access for the patient.

2.9.8 Trust Five Year Integrated Business Plan 2014 – 2019

The IBP specifically identifies the Emergency Floor project as an urgent development as a key plank of the health system's plan to resolve its longstanding problems with emergency care.

2.9.9 Trust's Five Year Estate Strategy June 2014 (Appendix 2I)

The Trust has undertaken an exercise to review the strategic future of its estate, with a view to creating a development control plan that looks twenty years ahead. "The quality and fitness for purpose of the NHS Estate and the services that maintain it are integral to delivering high quality, safe and efficient care"[21]. It is also an area of significant spend; the budget for Estates and FM Services across the Trust in 2013/14 was £31m.

The Trust's estate strategy identifies the need for flexibility to move property from being a constraint to an enabler for change. UHL is developing a Hospitals Estate Transformation Plan which is based on a strategy that consolidates the estate, develops new facilities, disposes of surplus land and buildings and encourages third party partnerships that will raise income for the Trust. This will be a cornerstone of service reconfiguration and improved utilisation of the Trust's estate. This must be balanced by organisational and public expectations about the provision of highly specialised services alongside local access to primary and secondary care, in the

[21] Treasury Value for Money Update, 2009

context of high levels of public support for the associated hospitals. It is in this context that the opportunity for significant and far reaching estate transformation will be determined.

The Transformation Plan will;

- Underpin the strategic direction
- Support the clinical strategy to improve patient pathways and improve quality of care
- Support the strategic outline case for the whole site reconfiguration
- Show a clear implementation programme over five years for transformation with tangible benefits
- Improve the patient and staff built environment, investing in improved facilities and infrastructure; greatly aiding recruitment and retention
- Identify capital development to unlock the embedded value of Trust assets and support its ability to deliver clinical transformation and achieve QIPP efficiency savings

Efficient estate solutions will improve frontline service provision as well as achieving improved utilisation of the estate and unlocking its embedded value. This is possible by delivering a high quality clinical and working environment for patients and staff, resulting in better levels of productivity, flexibility and patient satisfaction. This will also support cross-CMG strategies that maximise optimisation of the estate resources across UHL. This strategy is relevant to this business case; the Estates Transformation Plan will set out detailed strategies for its three main hospital sites. The Emergency Floor Project is considered key in this plan in supporting the Trust's service strategies by enhancing specialised services through consolidation of the Emergency Floor at the LRI. This project is the first to progress in a 5 year programme to reconfigure the Trust's hospitals.

Non Financial Benefits

The consolidation of the Emergency Floor at the LRI provides non financial benefits by vacating key clinical ward space on the LRI site, which ultimately realises the potential for space to be vacated at Leicester General Hospital by the transfer of services. This is integral to UHL's Five Year Strategy.

This also supports the intention of the Better Care Together strategy to make better use of the collective asset base and to provide services from the most appropriate acuity setting. This strategy is supported by the Estate Transformation Plan and is central to the health partners plans, encompasses a wide range of proposed changes and is a key priority for the local NHS over the next three years.

2.10 Summary

Key national and regional business strategies suggest that the urgent and unscheduled care environment in the NHS is changing significantly, with a number of initiatives underway to reduce ED attendances and non-elective admissions across LLR.

At the same time, the Better Care Together Programme and the integrated transformation programme are underway which identify how and where acute care is provided. LRI emergency services have an important role to play in supporting UHL and the entire health economy with the increased activity which is projected; highlighting LRI as a main emergency service provider for the region.

Part B: The Case for Change

2.11 Introduction

The purpose of this section of the business case is to outline the strategic case for change. Emergency Medicine is a secondary care specialty which provides immediate care for patients of all ages presenting with illness and injury of all severities[22].

Utilising the BCT Case for Change Framework, the case for change for the EF has been summarised in the diagram below:

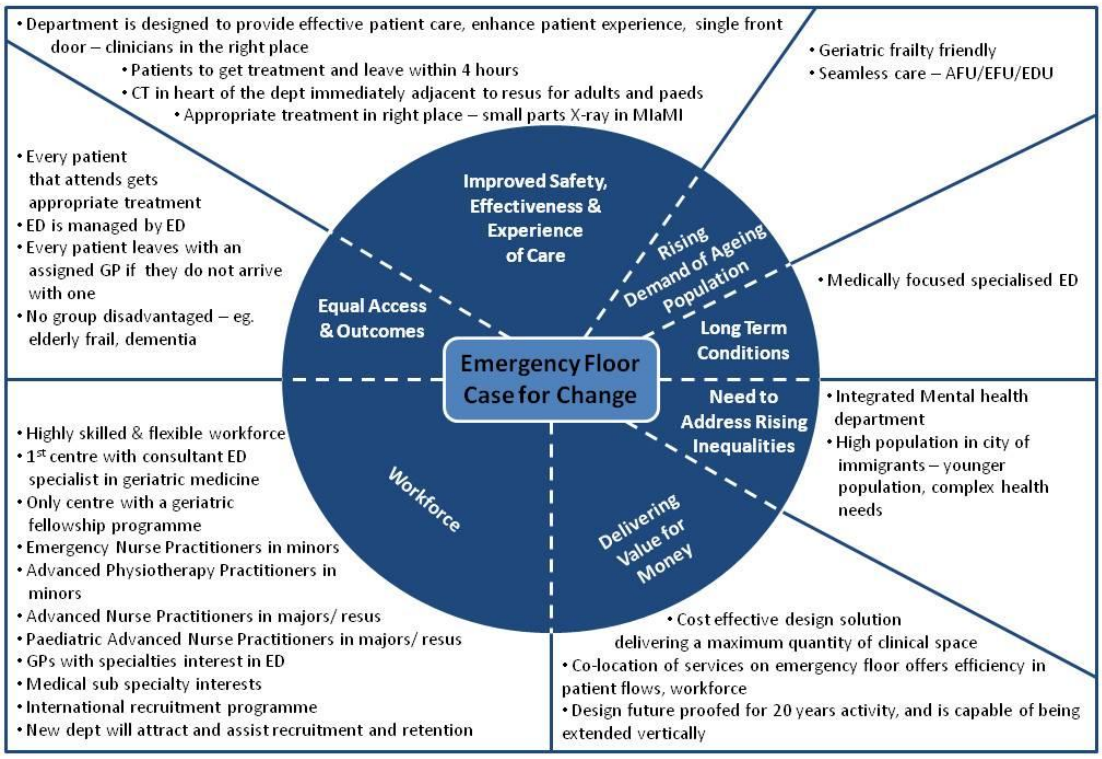


Figure 2.H Emergency Floor Case for Change

2.12 Clinical Drivers for Change

- The increasing demand for emergency services is greater than the current capacity can provide. Historic trends in growth suggest a 5% annual growth in ED activity and 3.5% annual growth in medical assessment activity
- Requirement for single floor Emergency and Medical Assessment Department that incorporates key adjacencies and presence of diagnostics and medical assessment services on the same floor. This enables implementation of the developed model of care for both adults and children accessing emergency services

[22] The College of Emergency (2011, February). What is Emergency Medicine? A guide.

- Changes in the local and national demographics combined with the Trust's plan to remain an Emergency Care Centre for Leicester is impacting on increased emergency care demand
- The Trust requires additional capacity to reflect NHS national guidance. The Emergency Floor project reduces the risk of compromising compliance of other standards of care such as quality, infection control, emergency and urgent care standards and commissioning standards
- The Trust needs to be in a position to be named as a 'Major Emergency Centre' as outlined in the Urgent and Emergency Care Review November 2013 – End of Phase 1 Report (Keogh)
- The requirement to address the 4 hour target and clinical handover (ambulance to trolley) transfer times will have a significant impact on Trust's financial performance if capacity issues are not resolved
- Redevelopment and increased capacity will provide opportunities for the Trust to fulfil its strategic redevelopment programme

The clinical justification for creating a new Emergency Floor is strong. Appendix 2J articulates the detailed clinical case for change as identified by lead clinicians. Key themes are summarised below:

2.12.1 Lack of a single front door[23]

The Urgent Care Centre and ED are currently in different buildings separated by a large slope/ lift journey. This physical separation prevents the efficient assessment and streaming of walk in attendances at the UHL site into the most appropriate stream. Currently there is duplication of booking in and triage/ assessment leading to a fragmented patient journey, resulting in a delayed and poor patient experience.

It has also been identified by the Specialist Commissioners for Children & Families that UHL requires a "single front door" for all acutely unwell/ injured Children & Young people. The implementation of the optimal service for children is hindered, fundamentally, by current geographical space – neither the Paediatric ED nor Children's Assessment Unit (CAU) is large enough to safely manage the current volume of patients.

2.12.2 Inadequate footprint and capacity of all areas

The number of patient cubicles in each area of the department is too low, meaning that patients are often left to wait in corridors or in the middle of the department. In addition high acuity patients are often seen in lower acuity areas which are not appropriate to their needs.

- **Resuscitation:** almost hourly a patient has to be moved out of Resus before the clinically appropriate time to make way for an incoming ambulance patient; similarly some new arrivals who should be seen and stabilised in Resus are refused entry and have to go directly to Majors. There are issues moving patients from Resus onto the wards which causes further blockages in the ED. There is documented evidence of patients who have come to hard as a result of not being in Resus.

[23] Acute and emergency care: prescribing the remedy; College of Emergency Medicine

- **Majors:** often there are patients in Majors who are not in a designated patient space due to overcrowding; they are parked on trolleys in the middle of the department, directly next to each other, with no privacy or dignity, no provision for relatives, an inherent infection control risk and in breach of fire regulations.

Figure 2.I Patients in the middle of Majors

- **Initial Assessment:** patients often have to wait in their ambulance being cared for by paramedics until a space for them in ED is available, causing significant queues in the ambulance bays. This also stops ambulances getting Resus/ Majors patients into the department. Delayed access to ED leads to patient harm as patients may deteriorate whilst waiting or not have the severity of their condition recognised and have a delayed time to critical intervention/ treatment.

2.12.3 Physical layout of the department is inefficient in terms of adjacencies

The ideal patient journey should be “assess once, investigate once, and decide once”; however the physical estate does not allow this to occur. Inherent in the current model is obvious duplication of patient and staff processes.

- Resuscitation is not located adjacent to Paediatrics, meaning that Paediatric patients have to pass through adult areas to move to/ from Resuscitation
- Diagnostic Imaging facilities are not adjacent to the ED and therefore patients needing urgent CT scans/ X-rays have to travel 45-60m at high risk if the patient deteriorates while in the Imaging Department. Transfer times are inefficient creating delayed treatment times and a significant drain on staff time while they accompany patients to and from the Imaging Department
- Resuscitation bays are laid out in such a way that the majority of them are not visible from the staff base, and there is very limited space for additional staff touch-down points in the zone
- In Majors, when patients are parked on trolleys it obstructs access to patients both in and out of cubicles and significantly slows down staff and processes. When cubicles become occupied with patients who need to remain on oxygen/

need monitoring/ are an infection control risk this often only leaves 1 or 2 cubicles remaining to see all new attendances requiring multiple patient and trolley moves

- Initial Assessment spaces are located immediately inside the main ambulance entrance, and therefore activity in this area can obstruct access directly to Majors. There are pillars in the corridor which hinder visibility from the staff base
- When children arrive in the ED, they are assessed by nursing staff, often seen by junior doctors, reviewed by senior doctors, and a decision is made to admit the patient to CAU. This process is then repeated on CAU. It is a constant factor in feedback from patients and families that their journey is replicated. It also leads to complaints of perceived limited communication between the two areas (due to the replication of processes). It prolongs the overall patient journey and could be delivered in a more efficient manner
- As there are 2 entry points into UHL for acutely unwell/ injured children and young people, similar levels and grades of staff are required in CAU and Paediatric ED. This separation of staff prevents effective working and a united patient experience
- The EDU and EFU are based in another part of the LRI - geriatricians have lost the connection with the front door which reduces ability to influence management from the front door effectively. Communication and dialogue with ED colleagues is not effective and this leads to unnecessary admissions to LRI for patients whose needs could be met in the community
- Admitting the patient to another part of the hospital builds in a further level of delay – it is more difficult to access diagnostics such as X-ray and CT scanning for example, which subsequently delays the patient's final management plan
- The multi-disciplinary team (therapists and specialist nurses) work between ED, the medical assessment service and the frailty units. This is disjointed as the units are 5 floors apart and the therapy store is in a different location all together

2.12.4 Individual patient spaces are too small and inconsistently designed

Few patient spaces have doors: none in Resus and only one bay in Majors. Many patient spaces do not have walls between them i.e. they are surrounded on three sides by a curtain or screen creating a significant infection control risk and a poor patient experience in terms of privacy and dignity. The inconsistent design of patient spaces (including size, shape, equipment location, storage provision) means that staff have to work differently in different spaces which is hugely inefficient.

- **Resuscitation**: each bay is too small, causing significant problems for multiple staff looking after the sickest patients. The design of fixed equipment is inappropriate and staff have limited access to the patient's head. The majority of bays have one wall, two dividing screens, and one curtain across the front – so there is no physical separation of sounds and smells between bays. This is especially inappropriate as the Resus zone caters for both adults and children. For example:
  - grieving family post cardiac arrest next door to a child with an asthma attack
  - violent, aggressive and verbally abusive patient under the influence of alcohol/ drugs requiring rapid tranquilisation next to a patient near end of life with their relatives

- **Majors:** cubicles are of random size and geometry, and are too small. Several are not large enough to accommodate anything other than a patient trolley; there are none with negative flow, none with en-suite facilities and only 1 with a door. In a modern, fit for purpose department all Majors cubicles should have walls separating them from adjacent cubicles and glazed doors at the front to provide audio/ visual separation, while maintaining clinical observation where required
- **Minors:** the cubicles are too small and all have different layouts due to geometry so it is not possible to equip them out uniformly or have uniform processes. This results in staff leaving cubicles constantly to get equipment and patients being transferred to the treatment room for interventions, rather than being treated in their cubicle. The spaces are cramped and patients receive a poor experience while being seen in this environment
- **Initial Assessment:** the spaces are too small to perform a patient transfer from ambulance trolley to hospital trolley; therefore these transfers have to take place in the corridor, obstructing access to Resus and Majors. Staff are unable to perform their tasks appropriately and efficiently due to a lack of space – equipment has to be stored outside of the spaces and staff have to retrieve it when required
- **EDU:** this area has restricted bed spaces and cubicles, with AFU located in another area creating poor adjacencies and poor efficiencies. Integration of elderly, demented patients (EFU is embedded within EDU), mental health patients and others in same bays is a poor clinical model
- **Psychiatric area:** this is not integrated into EDU and hence at present not used to full potential - combining areas will negate the need for extra staff
- **Patient transfers:** patient transfers from trolley to bed are done in the lift lobby owing to inadequate space creating patient dignity and privacy issues. This includes bariatric patients who require hoisting from a trolley to a bariatric bed

2.13 The Model of Care

2.13.1 Underlying Principles

The LRI Emergency & Medical Assessment Services are part of an integrated network of facilities in the area that provide assessment and treatment services for adults and children who require unplanned care; 24 hours a day, every day.

Existing primary care centres, minor injuries units, walk-in centres, and NHS 111 will remain the first point of access to the NHS for most patients with emergency problems. The principles that underlie the Model of Care for the proposed Emergency Floor are as follows:

- High quality care delivered by a well-trained and educated workforce resourced to meet the projected case mix and workload
- A no-wait philosophy
- Effective streaming of patients to an appropriate point of care
- The ‘see and treat’ principle to underwrite all ED activity
- A co-ordinated ‘one-stop-shop’ approach for unplanned care providing equitable access to all agencies including mental health liaison teams, social services, etc

- Minimal patient moves
- Minimal steps in processes/ hand-offs
- Integration of diagnostic and medical assessment processes
- Access to senior clinical opinion from the earliest point in the patient pathway and onwards
- Flexibility of resources, both physical and human, to deal with changing workloads and case mixes
- Using the skills and expertise of professional staff flexibly, with joint training in order to transfer skills
- Protocol-led care with standardisation of patient pathways integrating the input of all care practitioners (e.g. OT, social services, etc)
- Improved junior doctor training and improved skill mix
- Optimised use of technology, including integrated IT (ICRS, PACS & EPR) and near patient testing
- Design for patient safety, privacy & dignity, including age-specific facilities for the young and the elderly – the latter encompassing a 'frail friendly' approach to design

Following agreement of the aforementioned principles, the project Steering Group and key stakeholders have developed specific models of care for both Adult and Children's emergency services to be implemented into the proposed Emergency Floor development. These will provide new ways of working, improved process flows, improved efficiencies and continued safe care.

2.13.2 Adult & Paediatric Models of Care

Appendix 2K details the Model of Care; however they are outlined in the following diagrams.

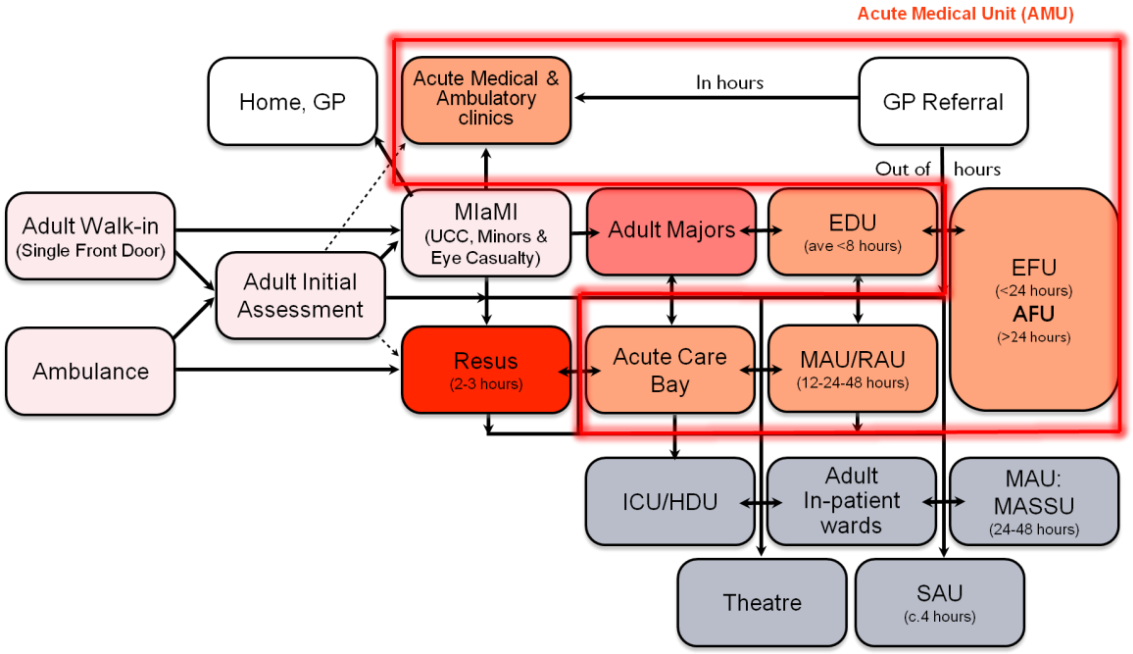


Figure 2.J Adult Model of Care

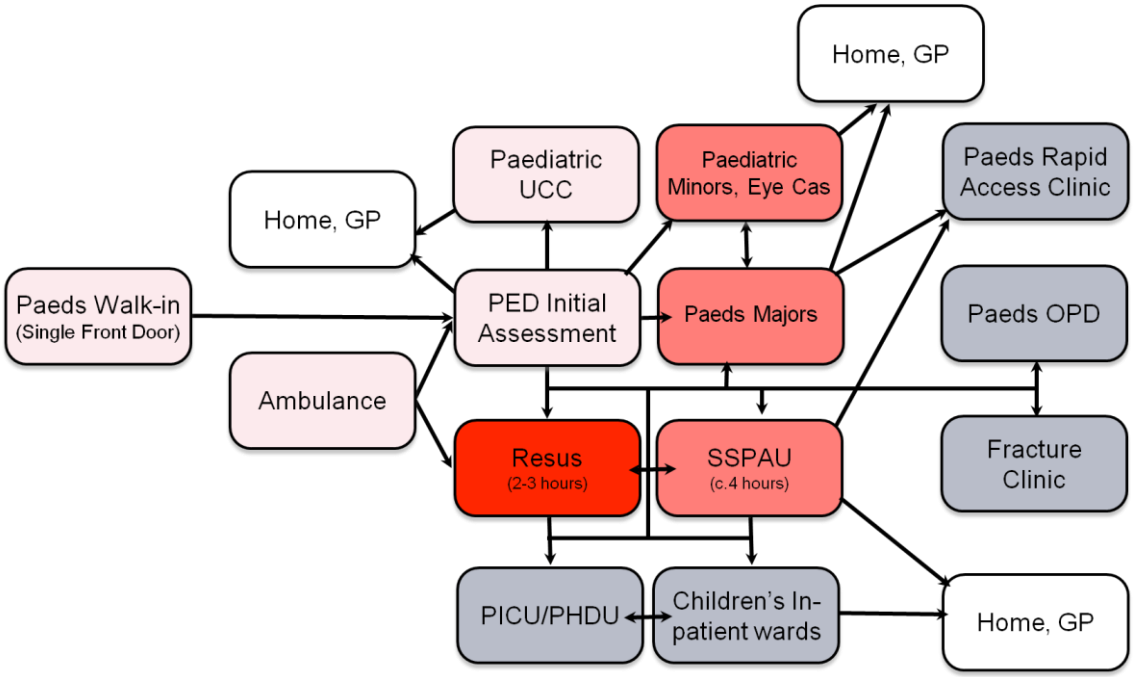


Figure 2.K Paediatric Model of Care

N.B. Paediatric Emergency Ambulatory Care takes place in Paediatric ED Minors.

The Trust is expected to provide high quality emergency care and medical assessment services to comply with regulatory standards. It also needs to ensure that its patients can receive treatment which is efficient and timely in its delivery, and its staff can work in a safe environment. In order to do so, provision of adequate cubicles/ bays for majors, mental health, minors, imaging, resus, paediatrics, medical assessment and supporting infrastructure accommodation/ environment will be required, to support the specific service delivery requirements relating to the associated emergency and medical assessment care.

The underlying principles were agreed by the following:

- Emergency Floor Project Steering Group and associated clinical teams
- Emergency Floor Project Board
- Joint Health & Wellbeing Boards
- Commissioners

The Developed OBC was approved by the CCG Managing Directors in November 2014. This FBC will be presented to the UHL Trust Board for final approval in February 2015.

2.13.3 Clinical Operational Policies

The Operational Policies have been developed for all services and associated departments to detail how each relate to each other, so that the department is planned in a functional way.

Each Clinical Operational Policy is designed to:

- Assist all healthcare professionals involved in the provision of emergency care services
- Outline the purpose and function of the clinical services provided in the Emergency Floor and its inter-relationship with the UHL bed base
- Ensure that all staff using the facility understand the philosophy of the service and work as a team with a comprehensive understanding of patient flow upstream and downstream
- Describe the service flow into, through and out of the department
- Describe the services as they will be delivered for the future
- Describe the purpose and function of the accommodation required
- Identify adjacencies/ co-locations required for the service delivery
- Outline requirements for business continuity and interaction with the major incident plan
- Outline requirements in event of department lock down
- Outline legislative and mandatory requirements for the delivery of services

The Clinical Operational Policies produced to date are appended at Appendix 2L, 2M and 2N.

2.13.4 Adjacencies

An adjacency matrix has been developed to understand travel distances and times for staff, patient and goods flows (see Appendix 2O). As a consequence it is understood that the following adjacencies need to be achieved, minimising crossover with public routes in all instances:

Within the Emergency Floor

- Resuscitation to be adjacent to Adult Majors and Paediatric Majors
- Resuscitation to be adjacent to CT scanning facilities
- Paediatric ED and Adult Majors to be adjacent to Imaging facilities (CT and X-ray)
- Paediatric ED to be adjacent to SSPAU
- MIaMIEE to be adjacent to Adult Vertical Streaming Zone
- Ease of admission from the Adult ED front door to the AMU
- Ease of admission from the Paediatric ED front door to SSPAU
- EFU adjacent AFU
- EFU adjacent EDU
- EFU/AFU close to, and preferably adjacent to, RAU
- RAU adjacent ACB
- RAU close to, and preferably adjacent to, ED Majors
- ACB close to resuscitation facilities
- All medical assessment beds to be close to the GP Referral Unit and Ambulatory Care Centre
- Access to other pathology services including haematology, biochemistry, transfusion and the blood bank. Much of this adjacency shall be met through

provision of a dedicated pneumatic tube system to the hot lab within the new floor and a pneumatic tube connection to the main pathology department

External to the Emergency Floor

- Ease of access for adults to the adult critical care unit (ICU)
- Ease of access for children to the paediatric critical care unit (CICU/ HDU/ Ward 12)
- Ease of access to operating theatres
- Ease of admission to in-patient wards
- Ease of access from AMU to the short stay unit
- Direct access to shared staff support facilities (including offices & staff change)
- Access to whole-hospital clinical support services such as security, mortuary & post-mortem services, FM services (including laundry and catering)

It is essential that paediatric patients are provided with dedicated child-friendly facilities separate from adult patients. Where shared use of facilities is unavoidable (e.g. in the resuscitation area), provision must be made for child-friendly decoration and distraction (e.g. facilities to play DVDs) where possible.

The design should separate the flow of patients, visitors and goods wherever possible. This is particularly important where there is the potential for patients to be in a state of undress and/or distress.

The diagram below summarises the preferred adjacencies of the various zones across the proposed Emergency Floor.

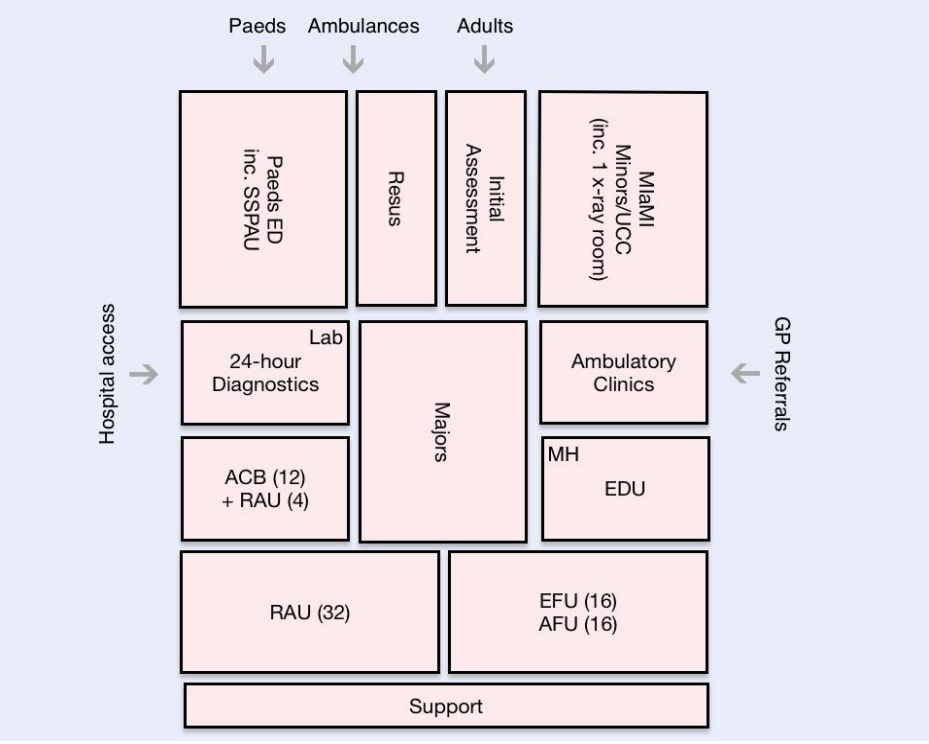


Figure 2.L Preferred Adjacencies

2.14 Current Activity & Demand

2.14.1 ED

In line with national concern about the ability of emergency services to cope with demand, UHL has experienced a rise in attendances to its emergency services; and its average performance is well below the standard 95%. This reflects poor quality of care for patients, reduced clinical effectiveness, and an unacceptable delay in treatment, increased clinical risk and compromised patient safety.

The current ED and associated medical assessment areas were originally designed to serve annual attendances of approximately 100,000. In the full year 2013/14, there were 151,568 attendances to the ED (including Eye Casualty) and 59,218 attendances to the UCC, which is currently in a separate location. 52,000 of the annual attendances are ambulance patients which are seen through a 16 cubicled majors area. Figures suggest there is an average 5-6% annual growth of emergency attendances at the Trust.

In response to a consistent underachievement of the 4 hour target, in November 2011 new clinical roles were introduced and a new pathway commenced called 'Right Place, Right Time'. This initially resulted in a considerable improvement in the Trust's ED performance. However, following a number of challenging weeks of activity (with ED attendances 5% higher and emergency admissions 7% higher in the final quarter of 2011/12 compared to the same period the previous year) achievement of the 4 hour target deteriorated. This is a contributing factor to the worsening financial performance and impact on achieving the Trust strategic plans.

It is important to acknowledge that the Trust has implemented the model of care that focuses on a single door entry point; whereby patients present to UCC first and then are referred to the ED if necessary. Although this initially seemed to improve performance the ability to achieve the 4 hour target is limited. This is primarily due to the current lack of capacity.

The increasing attendance levels create increased demand for major cubicles, minor cubicles and resuscitation beds and ultimately impacts on waiting times. Inadequate space, the inadequate size of the department and the poor layout currently compromise patient flows and results in patients waiting on trolleys and queuing in the open floor space in the majors area. As well as compromising patient privacy & dignity, this inhibits the Trust's ability to move patients smoothly through the emergency pathway and creates an unnecessary infection control risk.

Recent figures in relation to the 4 hour target can be seen in tables 2.5 and 2.6 below.

Table 2.5 2013/14 Full Year 4 Hour %

	Attendances	Breaches	% < 4 hr
Emergency Department & Eye Casualty	151,568	24,402	83.90%
Urgent Care Centre	59,218	63	99.89%
Total	**210,786**	**24,465**	**88.39%**

Table 2.6 2014/15 Full Year to Date (as per 11/11/14) 4 hour %

	Attendances	Breaches	% < 4 hr
Emergency Department & Eye Casualty	93,266	13,697	85.31%
Urgent Care Centre	39,134	93	99.76%
Total	**132,400**	**13,790**	**89.58%**

2.14.2 Medical Assessment Service

The medical assessment service (RAU & ACB) is currently on the 5th floor of the Balmoral Building. This location creates inefficiencies in patient flows and use of workforce, as staff are based in two locations creating inefficiency and potential duplication. Whilst improvements in patients flows are being undertaken in the interim, it is essential in the long term that this service be provided on the same floor as the ED with additional capacity to enhance efficiencies and meet demand. The medical assessment service provides a Rapid Assessment Unit (RAU) and Acute Care Bay (ACB) that are essential in providing an extension of care to the resuscitation, diagnostic and treatment. The service also receives referrals direct from GPs; however as there are often no beds available on the unit, these patients are diverted to the ED for treatment. This is an incorrect patient process which will be resolved in the new Emergency Floor.

Medical assessment activity has recently been growing at around 3.5% annually and the adjacency to the ED will assist in managing this growth rate by streamlining patient pathways and flows.

2.14.3 Diagnostics

The existing ED and medical assessment service have no dedicated emergency imaging suite. When ED patients require diagnostic services they are required to attend the main imaging department (45-60m away from ED, and 5 floors away from the medical assessment units), and at times require a porter and/or nurse to transport the patient to these facilities.

The requirement for a rapid, reliable diagnostic imaging service as part of the emergency patient pathway is increasing, with growing demand for the assessment of patients with trauma, stroke, and other conditions in line with national guidance. It is likely that demand for cross-sectional imaging will continue to grow and this proposal incorporates a strategy for future enlargement of capacity.

The pathway of care can be overlaid on this whole-system approach, and it has four key stages:

- Identification of the need for care (by self, by carer, by professional, by other)
- Assessment of need (by telephone, by face to face)
- Initiation of right response (emergency response, urgent response, rapid/ moderate response and integrated health and social care) – outlined in more detail below
- Follow through to closure (episode complete, planned follow-up, on-going care)

A diagnostic suite that is central for all patients within the Emergency Floor will provide improved patient flows and reduce the time taken to diagnose patients. Staff efficiencies will also be enhanced by gaining back the time that staff spend each day escorting patients to the main imaging department.

Diagnostic Turnaround times are identified in Appendix 2P.

In a similar fashion, the project includes satellite pathology and pharmacy facilities in order to provide local diagnostic testing and pharmacy dispensing. It is expected that the physical proximity of these facilities will engender truly multi-disciplinary working within the emergency service, as well as improving the turnaround times for pathology tests and the dispensing of medications.

2.14.4 Increase in Demand

The overall increase in demand at the ED and associated Medical Assessment service is comprised of a number of key drivers that include:

Local Demographic Factors

- The local community is an ageing population and there has been growth in the number of frail patients and those suffering from dementia
- LRI ‘minors’ attendances tend to be of a higher acuity (fractures/significant soft tissue injuries) than the nearby walk in centres at Loughborough or Leicester City Centre. This is due to patients with lower acuity minor injuries choosing to be seen at these centres (approx 150,000 between the three walk in centres), leaving the higher acuity cases to be treated at LRI ED
- UHL’s emergency services serves a population of approximately 1 million, making it one of the largest emergency services departments in the country
- There is no other ED within a 25 mile radius
- The local community lack confidence in the GP out of hours service which has increased pressure on EDs
- The local community has one of the highest birth rates in the country, generating additional paediatric workload

Service Development Factors

The proposed Emergency Floor project will be a significant driver in the Trust’s LRI site wide reconfiguration plans. The development will immediately begin to address the site’s lack of clear demarcation with regards access/ egress arrangements for staff, public, patients and blue light, by creating a ‘hot’ end to the LRI site.

Currently the hospital’s main entrance is immediately adjacent to the ambulance and walk-in drop off point for ED, which provides very little privacy and dignity for patients and their families. There are also considerable health and safety issues with regards the number of people in the vicinity in conjunction with ambulances and other vehicles operating in and around the same area.

The proposed development will separate blue light access/ egress away from the hospital’s main entrance in Balmoral. A site wide parking solution will also be

developed in parallel, with an immediate aim to alleviate vehicular congestion in and around the site during peak times.

2.14.5 Future Activity Scenario

The Trust has undertaken extensive work as part of the Better Care Together (BCT) programme, projecting ED and Medical Assessment activity for the next 5 year period. This work has concluded that UHL will see a 7.8% reduction in ED attendances over the next 5 years. This reduction is not applied uniformly across all areas of the department as high acuity resus/ majors patients are not likely to be diverted from the acute hospital setting into community services. However lower acuity patients such as those with minor injuries or minor illnesses could be diverted and therefore this is where the reduction in overall activity will be achieved.

At the time of writing the Developed OBC (August 2014), the Trust's Long Term Financial Model (LTFM) was not aligned to the BCT planning assumptions, as the LTFM had been submitted to the NTDA prior to the release of the BCT information. Therefore the two activity projections were not aligned, and the NTDA agreed that the Developed OBC would reflect two activity scenarios. However, it was outlined that the FBC would need to present a single scenario.

The Trust's ED attendances have continued to increase during 2014/15 and consequently neither model proposed in the Developed OBC reflects a realistic way forward. Following discussions with the CCGs, a pragmatic approach has been agreed which uses the forecast outturn activity for 2014/15 as the baseline; and then applies the BCT assumptions over the subsequent 5 years using 2015/16 as year 1. Years 6-20 will follow demographic growth in line with the Office of National Statistics (ONS); an annual increase of 1% for ED and Clinic activity, and 1.5% annually for medical assessment activity. This single model is outlined in more detail in Section 3.3.

In addition to the activity projections, the Trust has also undertaken activity analysis relating to hourly arrival percentiles. The 85th percentile number of hourly arrivals across the entire unit is in the region of 40 patients per hour. On occasions this volume may recur for two or three hours at a time. For the purposes of planning the new department, the capacity requirement was based on 95th percentile hourly arrivals. However as part of the Developed OBC this requirement was revised following NTDA feedback and is now based on 85th percentile hourly arrivals. It is important to note that efficiencies are impacted by the extent that patients occupy clinical spaces – resus bays, majors cubicles, etc – purely for the purpose of waiting (e.g. waiting for diagnostics or transfer, rather than for clinical intervention). In addition to capacity it is essential that adjacency requirements are considered and the associated impact on efficiencies and patient experience. This is particularly relevant for both the medical assessment and diagnostic services.

2.15 Schedule of Accommodation to inform the Option Appraisal Process

To enable a design to be produced, a complete room by room Schedule of Accommodation for all proposed departments across the Emergency Floor was first required, based on the Activity & Capacity modelling undertaken. This schedule was

developed at a series of clinical user group meetings with the clinical and associated managerial staff that make up the Project Steering Group.

The HBN compliant iteration of the Schedule of Accommodation required a net area of 7,885.9m^2 and was developed to reflect the design options for consideration during the option appraisal stage to eventually determine the preferred option. All options were based on an overall net floor area requirement of 7,200m^2.

Evolution of the Schedule of Accommodation to inform the developed solution has been described in the Estates Annex document, which can be found at Appendix 2Q.

2.16 Quality of Care

It is important to consider Quality of Care within the framework of the five domains of quality as defined by the Care Quality Commission (CQC). These five domains are:

- Safety
- Effectiveness
- Caring
- Responsive to people's needs
- Well led at organisational, hospital and service level

Table 2.7 Quality of Care by CQC Domain

Department	Description	CQC Domain
ED Front Door	In line with current guidance (DH and CEM) there is a requirement for one front door for adult patients presenting for emergency treatment. Patients will be streamed on arrival depending on their presentation. Reception staff will direct patients to the appropriate area, requesting the support of a nurse where clinical assessment is required, A separate front door is required for paediatric cases in line with National Service Framework (NSF) for Children and Young People A dedicated ambulance entrance would also be provided.	Safety Responsive to people's needs Caring Effectiveness
Paediatrics	UHL needs to meet the NSF for Children and Young People standards relating to discrete space and child friendly environment. The department will require an increase in cubicle numbers to cater for the attendances and the proposed growth, and will incorporate a short stay facility, including the potential shift of paediatric emergency care from an adjacent hospital. A dedicated paediatric single front door will ensure a child-focused approach to emergency care for children.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Majors	Currently there are 16 majors spaces; with additional ad-hoc chairs doubling up in cubicles and	Safety

Department	Description	CQC Domain
	the ED corridor. Activity/ capacity analysis carried out demonstrates that there should be a significant increase in numbers of cubicles in order to serve the attendances. The proposed change will provide the following: • Patient safety – providing compliant space around the bed for major incident and patient access • Privacy and dignity for patient • Compliance with infection control standards • Patient satisfaction and sustainable enhancement of the patient experience • Cubicle space to accommodate ambulance arrivals to the Trust, addressing the current delays with ambulance handovers into the unit	Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Resuscitation	Currently there are 6 spaces, which are not sufficient to meet demand. There is a need to improve efficiencies and increase the capacity in line with the activity/ capacity analysis carried out.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
EDU	There is a need to increase capacity (a combination of beds and chairs) to ensure efficiencies in flows across the emergency care pathway. This reflects a revised process flow as there currently is no EFU within the Trust and therefore some patients who are currently seen in EDU will be seen in EFU in the new build.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
EFU	There is a need for an independent EFU unit (separate from EDU) which will work flexibly with the AFU to provide comprehensive geriatric assessment at the earliest point in the patient pathway. Activity/ capacity analysis has been carried out to inform the appropriate number capacity of the unit. Sufficient capacity is required to ensure efficiencies in flows across the emergency care pathway.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Minors	Current facilities prohibit staff efficiencies and cause poor patient flows.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Diagnostics	There is currently no dedicated emergency imaging	Safety

Department	Description	CQC Domain
	suite; patients are required to attend the main imaging department. A diagnostic hub that is central for all patients within the ED will provide improved patient flows and reduce the time to diagnose patients. Staff efficiencies will also be enhanced by gaining back the time that staff spends each day escorting patients to the main imaging department.	Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Mental Health	There is a need to meet requirements relating to a dedicated area that can be secured off from the rest of the department. This is required in order to provide appropriate facilities for patients with Mental Health conditions to ensure their clinical needs are met. This area will be provided within the EDU, slightly remote from the main ED to ensure minimal disruption to critically unwell patients. Consideration regarding provision of a separate entry/ exit to the department in order to enhance compliance to Section 136 requirements is essential. Activity/ capacity analysis has been carried out to inform the appropriate number capacity of the unit.	Safety Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level
Medical Assessment	There is an essential need to provide a medical assessment service adjacent to the ED and diagnostic suite to enhance patient flows through the department, with the benefit of improved working relationships, processes and clinical effectiveness for patients.	Responsive to people's needs Caring Effectiveness Well led at organisational, hospital and service level

In addition to these domains, the CQC implemented an 'Intelligent Monitoring' approach (October 2013) to assess which Trusts would be visited first in the next wave of CQC inspections. This approach is based on 150 indicators that look at a range of information including patient experience, staff experience and statistical measures of performance for example whether a Trust is hitting the ED 4 hour wait target. The Trust is then banded between 1 and 6 (Band 1 represents a higher risk than Band 6). UHL is currently banded by the CQC as Band 1 and therefore representing a high risk with ED performance viewed as a key indicator in this banding.

The CQC undertook an inspection visit in January 2014, with specific areas for inspection and ratings as follows:

- Accident & Emergency – requires improvement
- Medical Care – requires improvement
- Surgery – requires improvement
- Intensive/ Critical Care - good
- Maternity & Family Planning – requires improvement
- Services for Children & Young People - good
- End of Life Care - good

- Outpatients - good

The CQC Inspection Report for the LRI can be found at Appendix 2R. Actions have been identified as a result of the CQC visit and are being implemented across the Trust.

2.16.1 Impact of Difficulties in Recruiting & Staffing

Nationally, there is a declining medical workforce specialising in the area of Emergency Medicine. Whilst there has been a successful recruitment drive at LRI for all levels of staff, the unit remains short-staffed and has to place a heavy reliance on agency staff, which is further exacerbated by the poor environment resulting in a difficulty recruiting.

Whilst ongoing operational improvements are being made to ED processes, the proposed investment and development of the Emergency Floor is the Trust's strategic response to ensure that there is sustained delivery of the emergency care. For those who have to attend hospital, care will be provided in an environment designed to deliver a better patient experience and better quality outcomes.

Future proofing of emergency care provision and changes in patient activity in line with national and regional models of care make it timely for the Trust to review and identify options for enhanced emergency care provision at the LRI, as well as the environment it is delivered in.

The Trust believes that some of the barriers to recruitment and retention of specialist ED staff are as follows:

- Inadequate working environment leading to substandard patient care and increased risk of adverse incidents. This in turn impacts on staff and presents risk of staff stress and increased sick leave
- Inadequate training facilities based on limited capacity and flexibility of emergency care infrastructure

The difficulty in recruiting is highlighted by a recent example where the Homerton University Hospital NHS Foundation Trust and UHL placed adverts for ED Consultants at the same time; the Homerton received 5 applications from suitable candidates whereas UHL received none.

A consolidated centralised unit designed to meet capacity, will contribute to attracting emergency medicine staff to the Trust. Attracting high quality senior clinicians will also further enhance the quality of training and education, creating a sustainable supply of future workforce. This not only impacts on the medical workforce but equally impacts on the nursing and support services which benefit from a highly trained and motivated medical leadership model committed to continuous professional development.

The above case for change relating to both capacity and quality manifests itself into what ultimately becomes a far from satisfactory patient experience. In July 2014 patient complaints hit an all-time high, with the receipt of 36 formal complaints as a consequence of service received from the ED. Some, but not all of these were as a

result of the ED physical environment. Between May 2014 and October 2014 a total of 165 formal complaints were received regarding ED.

2.17 Investment Objectives, Key Deliverables & Benefits Criteria

In the context of the above and the Trust's Corporate objectives outlined in Section 2.9, the 'SMART' investment objectives for this project are detailed below as part of the wider Benefit's Realisation Plan, clearly outlining what the scheme is set to achieve and how.

It is important to note that agreement of the following from the Project Board, Steering Group and wider stakeholder group has informed the Qualitative Benefits Appraisal detailed in the Economic Case.

Table 2.8 Investment Objectives & Wider Benefits Realisation Plan

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
A. Business Need	**1.** To provide the Trust with increased capacity for emergency services to meet the demands of population growth, changing service models and improved efficiency targets.	To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care	• OBC and FBC approval • Planning approval • Efficient programme management	Provision of an Emergency Floor that incorporates the agreed SoA to meet capacity for ED and medical assessment services	• Trust and BCT activity and capacity analysis workings • SoA • Robust Programme plan and governance reporting mechanisms • Trust performance figures	Emergency floor redevelopment project complete and clinically operational – summer 2017	• Reconfiguration Programme Board • Trust Board
	2. To increase the productivity of emergency care at LRI	Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway	• Patient information • Improved patient pathway • Trust KPI targets	• Clinically appropriate transfer of patients • Length of time from arrival to start of treatment for urgent HRG group • KPI targets meet	• PLACE surveys and complaints register • Trust risk register	Summer 2017	• CMG • Transformation Board
	3. To develop a centre of excellence, enhancing the Trust's reputation for training, service delivery and treatment, through the provision of a	Support and consolidate the provision of emergency floor concept at LRI	• Robust Design process • Engagement of stakeholders • Key internal adjacencies compliant with Strategic guidance	• Reconfiguration will allow acute and emergency medicine to be co-located providing a new pathway for assessment and treatment • Clinically	• Emergency Department is on one single floor • Stakeholders agree and sign off on design • Diagnostics, medical assessment and ambulatory care	Commences at OBC and completed summer 2017	• Trust Transformation Board • Emergency Floor Project Team • CMG • PSCP

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
	centralised service in modern accommodation.			appropriate transfer of patients • Emergency Department centre of excellence (critical mass and centralisation of service)	clinics are implemented as key adjacencies		
B. Strategic Fit	**4.** To ensure that the changing needs and expectations of a growing population are met in line with Trust clinical strategy and national guidance standards	Ensures that the service model of care is delivered in line with National, Trust and local health economy KPIs	• Compliance to best practice standards and national and local KPIs	• Improved patient experience • Increased percentage of patients seen within the 4 hour target • Trust Performance and Emergency care KPIs met	• Patient survey (PLACE) • Current quarterly performance reports	Patient survey has to be carried out prior to implementation of new service	• CMG • Trust Transformation Board • Trust Board
		Patient safety is enhanced, and clinical risk is reduced.	• Model of care and design enhance efficiencies in achieving 4 hour targets and reducing waiting times to treatment	• Reduction in clinical incidents and complaints	• 2012/13 quarterly performance reports • Trust clinical risk register	Summer 2017	• CMG • Trust Board
	5. To provide an ED that is compliant with NHS building guidance	Where possible ensures that the service is developed in line	• Compliance to best practice standards and national and local	• Meets HBN guidance for ED and medical assessment	• 2012/13 quarterly performance reports • HBN guidance	Summer 2017	• PSCP • Trust Transformation Board

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
	standards	with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision	KPI s	environments • Agreed capacity provisions have been implemented • Improved A&E operational performance	documents • Policy directive documents		
C. Quality	**6.** To improve the clinical effectiveness and safety of urgent and emergency care service across Leicester	Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows.	• Model of care and design enhance efficiencies in achieving 4 hour targets and reducing waiting times to treatment	• Acute and elective pathways reflecting best practice • Increased percentage of patients in which 4 hour target is achieved • Decrease % in non-urgent HRGs in A&E attendances	• Current data • Quality indicators report • Quarterly performance reports	Summer 2017	• CMG • Trust Board
		The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety	• Robust Design process • Engagement of stakeholders • Key internal adjacencies compliant with Strategic guidance	• KPI figures reflect current benchmark relating to patient safety, referral, diagnosis and treatment time	• PLACE surveys and complaints register • Trust risk register • Staff surveys • 2012/13 Quality indicators • 2012/14 performance reports • Staff surveys	Summer 2017	• PSCP • Trust Transformation team • CMG • Capital Estates and Facilities Department
	7. To improve the clinical	Provides enhanced departmental	• Key internal adjacencies	Centralisation of acute medicine	• 2012/13 Quality indicators	Summer 2017	CMG

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
	adjacencies of services to optimise clinical safety and reduce clinical risk.	relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes	compliant with Strategic guidance	ensuring: • Patient focused pathways with more rapid and increased access to specialist care • Integrated admission avoidance • Decrease in unplanned hospitalisation for chronic ambulatory conditions	• 2012/14 performance reports • Staff surveys		
D. Sustainability, Service Modernisation, Value for Money	**8.** To facilitate the modernisation of services, including streamlining patient pathways and efficient working practices providing an ED that ensures adequate infrastructure and capacity for supporting services that are conducive to the needs of a modern workforce	Ensures facilities are future proofed and adaptable to the changing needs of the health economy	• OBC and FBC approval • Planning approval • Efficient programme management	• Provision of an Emergency Floor that incorporates the agreed SoA to meet capacity for ED and medical assessment services	• Trust and BCT activity and capacity analysis workings • SoA • Robust Programme plan and governance reporting mechanisms • Trust performance figures	Summer 2017	• CMG • Trust Transformation Board • Capital Estates and Facilities Department

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
E. Meeting Commissioners' intentions for healthcare services	**9.** To equip the ED to respond effectively to existing and known commissioning requirements, as well as to respond flexibly to future changes in service direction and demand.	Improved Privacy and dignity provisions for all patients	• Design provides adequate space for provision of care to patients accessing ED and eliminates double up in cubicle and trolleys in corridor	• PLACE scores/audits will reflect positive patient feedback	• PLACE surveys	Summer 2017	• CMG • Trust Transformation Board • Capital Estates and Facilities Department
		Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept	• Specialist ED and medical assessment staff are based in the department providing integrated care across patient pathway	• Reconfiguration will allow acute and emergency medicine to be co-located providing an enhanced pathways for assessment and treatment	• PLACE surveys and complaints register • Trust risk register • 2012/13 risk register • Staff surveys • 2012/13 Quality indicators • 2012/14 performance reports • Staff surveys	Summer 2017	• CMG • Trust Transformation Board • Trust board
	10. To improve the environment and the experience of users (patients, visitors and staff) at Leicester Royal Infirmary Hospital Emergency Department	Improved patient access through a single front door process	• Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders • Key internal adjacencies compliant with Strategic guidance	• Both Adults and Paediatrics will enter their specified ED department via single point of entry enabling efficiencies in initial assessment and improved patient experience	• PLACE surveys and complaints register • Trust risk register • 2012/13 risk register • Staff surveys • 2012/13 Quality indicators • 2012/14 performance reports • Staff surveys	Summer 2017	• CMG • Capital Estates and Facilities Department • Emergency care Directorate • PSCP

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
		Enhances patient, visitor and staff safety through the built environment	• OBC and FBC approval • Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders • Key internal adjacencies compliant with Strategic guidance	• Patient and visitors experience will reflect positive response • Trust audit and performance reports will reflect figures in line to current guidance standards	• PLACE surveys • Quality indicators • Trust incident reports	Summer 2017	• CMG • Transformation Board
F. Achievability	**11.** To provide a solution that is aligned to the Trust DCP plan and Trust organisation as a whole.	The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services	• Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders	• Post Project Evaluation highlights project is completed on time and ED services provided with minimal disruption	• Programme plan	Summer 2017	• Capital Estates and Facilities Department • Emergency care Directorate • PSCP
		Option enables future proofing of the physical Emergency Department environment aligned to DCP future expansion needs	• OBC and FBC approval • Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders	• The redeveloped Emergency Floor option ensures future expansion	• Programme plan	Summer 2017	• Capital Estates and Facilities Department • PSCP • Trust Transformation Board

Investment Objective	Project Objective	Benefit	Enablers	Outcome	Baseline Measure	Target date	Owner
	12. The development will be delivered on time with minimal disruption to current service delivery	The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery	• OBC and FBC approval • Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders	• Post Project Evaluation highlights project is completed on time and ED services provided with minimal disruption	• Programme plan	Summer 2017	• Capital Estates and Facilities Department • Emergency care Directorate • PSCP
		Reduces complexity and sequence dependency of enabling moves	• OBC and FBC approval • Planning approval • Efficient programme management • Robust Design process • Engagement of stakeholders	• Design process and programme plan implemented that utilised a solution with minimal complexity and dependency on enabling works/moves	• Programme plan	Summer 2017	• Capital Estates and Facilities Department • Emergency care Directorate • PSCP
		Maintains blue light access throughout whole build process	• Robust ambulance protocols • Compliance with ambulance protocols • Ambulance transfers between sites protocols	• Patients get to the right place first time • Ambulance service does not experience any delays in access to the ED during the build process	• Audit of conveyance decisions • Programme plan	Summer 2017	• Capital Estates and Facilities Department • Emergency care Directorate • PSCP

2.18 Benefits Realisation

Work has been undertaken by the Trust to identify and quantify the clinical benefits resulting from this project. These include:

- **Strategic Fit:** in keeping with the longer term site reconfiguration proposals, acting as an enabler to other service moves and relocation. Enables the co-location of services that supports evidence based practice, innovation in developing new models of care and provides a seamless service to adults and children. Supports the longer term vision for all children's services to be located on the LRI site.
- **Clinical Quality and Patient Safety:** early access to senior decision makers, immediate diagnostic support and visibility of patients will significantly enhance patient safety and improve quality of care
- **Patient Outcomes:** reduced harm, improved morbidity and mortality and opportunities for improved clinical outcome through early intervention supported by a no delays environment
- **Patient Experience:** responsive no delays system in a dedicated bespoke environment will reduce complaints, increase compliments and improve patient experience. The environment will enhance privacy and dignity and will reflect the needs of children and their families. The adult environments will be dementia and frail friendly.
- **Clinical Staff & Resources:** improved patient flow, proximity of services and an environment tailored to meet demand will increase staff satisfaction, improve morale and mitigate stress. Reduced sickness absence levels with higher rates of recruitment and retention as the emergency floor be recommended as a place to come and work. The floor will enable more effective ways of working and reduce duplication of work and facilitate collaborative interdisciplinary working.

2.19 Design Quality & Philosophy

The key objective is to provide a facility where clinical teams can provide a rapid and comprehensive assessment, diagnostic and early treatment service. To reflect the philosophy of service, a number of strategic design principles will apply:

- Minimisation of patient entrances to create a focus for initial clinical assessment and to maximise departmental security
- Notwithstanding the above, there should be rapid access for patients to the correct part of the service (e.g. avoiding sick patients having to pass through layers of reception, getting pre-assessed patients directly to a bed/service)
- Removal of bottlenecks and opportunities to wait
- Simple and visible waiting areas and circulation combined with IT solutions to keep patients informed of their wait/ progress in real time
- Careful balancing of the need for privacy and visibility
- Separation of patient groups where appropriate (e.g. majors from minors)
- Separate staff circulation routes discrete from main public waiting areas

- An environment that facilitates communication amongst the wider multi-disciplinary team, including the rapid response teams, therapists and social services staff who will be focused on preventing avoidable admissions
- Standardisation of the design of rooms within individual streams where possible so that a wide range of practitioners can use any room for patient examination and treatment. A standardised design will also ensure that all staff are familiar with the location of equipment and facilities in any space
- Plain film, ultrasound and CT diagnostic imaging facilities integrated into the emergency floor
- Pathology testing facilities integrated into the emergency floor
- Separation of treatment, waiting and appropriate environments for children
- Appropriate environments for patients with psychiatric conditions
- Secure staff support zone capable of controlled access from within the emergency floor and from elsewhere in the hospital

The design will reflect the importance of flexibility and quality, and will be informed by the latest design guidance where appropriate. It will be a contemporary building, respectful of locally sensitive areas. The building will not affect statutory and non-statutory designated sites. The preferred option design solution will enhance and improve on overall energy efficiencies, contributing to the NHS sustainability targets to reduce 2007 carbon footprint by 10%.

The following patient requirements should be met:

- Patients can be assessed and treated according to acuity of condition in a range of flexible clinical spaces
- There shall be high levels of patient privacy, notwithstanding the need for staff supervision. Patients shall in most instances be assessed and treated in individual rooms
- There must be sufficient space in assessment and treatment spaces for up to five staff to attend a patient on a trolley along with dressings trolleys and other equipment in position
- A patient/ nurse call system is essential through patient areas in the ED
- There must be adequate design and operational measures to prevent and contain the spread of infection. Clinical hand wash basins will be required in all assessment & treatment spaces, and a proportion of patient rooms shall have en-suite sanitary facilities to enable the isolation of patients

Throughout the Emergency Floor there should be appropriate facilities to separate patients with suspected infection from those who have not. In the Majors area of the ED there are 2 barrier nursing rooms with en-suite facilities to enable this separation. In the Resus area there are 2 barrier nursing rooms for the separation of patients who are too unwell to be treated in Majors. Within the longer stay areas, there is the following provision of single rooms with en-suites, where patients can be separated:

- EDU: 1 single room with en-suite facilities
- AFU: 4 single rooms with en-suite facilities
- RAU: 8 single rooms with en-suite facilities

- ACB: 6 single rooms with en-suite facilities

Shared sanitary facilities are designed to comply with both the consumerism standards regarding single-sex use as well as with relevant HBNs.

Clinical and nursing staff require:

- Sufficient space to examine and treat patients in privacy
- Facilities for isolating patients whose condition demands this
- Arrangements which discourage the outbreak of infection and limit its spread
- Ease of access to read and update patients' electronic notes and reports and privacy to discuss them
- Ability to teach without disturbing either staff or patients
- Space to talk to relatives in privacy
- Easy supervision of and access to patients especially for higher acuity patients
- Facilities for locating and summoning other staff quickly in an emergency
- Access to shared multi-disciplinary meeting space
- Space for resuscitation and monitoring equipment, the former located at or near the staff bases
- Space in WCs, bathrooms and showers to attend to a patient in a wheelchair, and to manoeuvre a mobile patient hoist
- Space in treatment rooms to attend to a patient on a trolley/ bed
- Short walking distances between patient areas and the main ancillary rooms
- Space for changing into uniform, hanging coats & storing handbags/ personal property; dedicated sanitary facilities; rest area with beverage preparation facilities

Visitors to the ED may be distressed and may become violent or abusive. Designers should consider means by which the design can contribute to a safer environment for all. This may include consideration of:

- The detailed design of items such as reception counters to reduce the potential for visitors and patients to harm staff
- The effect of ambient lighting systems to lower stress levels in reception and waiting areas
- The provision of secondary exits for staff to retire from abusive or violent situations to a place of safety
- Facilities to summon security to individual staff member location in an emergency
- The provision of panic alarm systems and the relationship of other security measures to the wider Trust security policy

2.19.1 Future Flexibility

Consideration of increased demand will provide opportunity for a solution that is flexible in functionality and that can provide capacity for current demand whilst enabling realisation of the 20 year capacity requirement.

A core component of the design solution will be the standardisation of the design of rooms within individual streams where possible, so that a wide range of practitioners can use any room for patient examination and treatment. A standardised design will also ensure that all staff are familiar with the location of equipment and facilities in any space.

For example within the ED, the MIaMIEE represents a combined and totally flexible area for the Urgent Care Centre and Minors. Majors is designed in two sections, half of which will be closed at quieter times of the day. In the event that there is a lack of outflow from the ED into the hospital, half of Majors can flex into an assessment area. The assessment areas are being planned with generic beds (except the Acute Care Bay) for flexibility.

In addition the structural design is such that it can take an additional floor at a later stage, in line with the Trust's Development Control Plan.

2.19.2 Design Quality Indicator Review

DQI considers the following three specific qualities:

- Functionality
- Build Quality
- Impact

It is deemed that if all three of these qualities are equal then there is an opportunity for design excellence.

An Independent Accredited Facilitator undertook a Stage 2 DQI Evaluation on Wednesday 2nd July 2014. The report provides details of the findings and makes recommendations for further improvement if it is required. The report can be found at Appendix 2S.

2.20 Potential Business Scope & Key Service Requirements

The Trust is seeking to resolve the shortcomings of its existing ED facility through the development of a purpose-built facility for the provision of emergency care. The lack of physical space and capacity in both clinical and non-clinical areas within the ED is affecting its performance in meeting the 4 hour standard and ambulance turnaround times, as well as the overall patient experience currently received. It also creates a significant safety risk when Majors and Resuscitation facilities are over capacity.

The current ED facility also lacks flexibility to accommodate any further increases in activity due either to population growth and/ or reconfiguration, which is reflected within the Trust's 5 Year Estate Strategy.

The following key service requirements have been identified to meet the current business needs:

- Increased capacity to meet current and future emergency service related activity
- Enhanced clinical adjacencies to facilitate better access to related core emergency care facilities and improved process flows
- Improved access to diagnostics (Imaging, Pathology & Pharmacy)
- Improved environment
- Improved retention and recruitment
- Alignment with the Trust's redevelopment strategic plans

The main components of the required scope for the new Emergency Floor are:

- Blue Light Ambulance Entrance
- Adult Ambulance Entrance
- Paediatric Ambulance Entrance
- Adult Reception/ Main Waiting Area
- Paediatric Reception/ Main Waiting Area
- Adult & Paediatric Urgent Care Centres
- Resuscitation (shared Adult & Paediatrics)
- Adult & Paediatric Majors
- Adult & Paediatric Minors
- Adult & Paediatric Eye Casualty
- Adult & Paediatric Emergency ENT
- Adult & Paediatric Procedure Rooms & Plaster Facilities
- Adult EDU
- Adult EFU/AFU
- Adult RAU
- Adult ACB
- Paediatric SSAU
- Diagnostic Imaging
- Pathology Hot Lab
- Pharmacy
- Simulation facilities
- Separate clean/ dirty utilities
- Supplies/ storage areas
- Disposal holds
- Seminar rooms and offices
- Staff facilities

As the LRI consolidates its role as a centre for emergency care across LLR, associated schemes such as an onsite Helipad are being considered, however the provision is currently met via the use of Nelson Mandela Park opposite the site.

2.21 Main Risks

Table 2.9 Main Risks and Counter-Measures

Risk	Mitigation
NTDA, CCG's, OSC's, Better Care Together Board and other key external stakeholders not supportive of the project.	Full engagement with all key stakeholders progressed from SOC stage onwards, with full involvement anticipated throughout the business case process. Regular routes for communication and update are in place via monthly executive forums.
NTDA approval and/ or funding not forthcoming.	Full liaison and engagement has been and continues to be undertaken, with the NTDA for approval of key milestones. The Do Minimum option would be pursued in the event of a lack of capital funding.
Planning & Highways – planning approval conditions	While planning approval has been granted, a number of conditions were imposed by Leicester City Council. If the project was unable to adhere to these conditions the Planning Approval would become invalid, with associated risk to the project.
Extended project programme - will result if an associated programme of enabling works are not progressed prior to FBC approval.	Trust Board have agreed to progress with required programme of enabling works at risk.
Delay - due to unforeseen demolition and construction risks.	Surveys carried out for M&E and statutory compliance related areas to identify potential issues in advance.
Service Disruption – The project impacts negatively on provision of emergency care services during implementation – significantly affecting patient outcomes and surgical services.	This risk is mitigated by an assessment of the programme and developing a project plan that limits disruption. Communication with design and project management team is essential throughout.

A pro-active risk management regime (detailed in Section 6.8) will be employed throughout the project. It is essential on any project (in particular one of this size and complexity) that the risk management process involves all key members of the project team including:

- Trust Estates
- Trust FM
- Project Consultant Team
- Contractor
- Designers

The current risk register (at Appendix 2T) has been developed through a workshop environment involving the above parties. For each identified risk the following are noted:

- Reference
- Category
- Risk and associated likely impact
- Probability and impact factors and associated overall risk rating
- Mitigation measures
- Cost and time impacts*
- Risk owner and / or manager
- Action Date

The register is reviewed regularly focusing on the high impact risks and those with pending Action Dates. Over time the allocation of the individual risks (Trust or PSCP) will also be reviewed to ensure risks are placed with the party best placed to deal with them.

2.22 Constraints & Dependencies

The constraints and dependencies relevant to the project are:

- **Better Care Together Programme:** the whole health economy has a strategy for improving Emergency Processes which this project must align to. This will include changing models of care to encourage fewer attendances to the Emergency Department
- **Budget:** the Trust has a limited capital budget, and must seek approval from the NTDA for any expenditure of over £5m of Treasury capital (i.e. excluding funds from donations).
- **Workforce:** the Trust has a strategic workforce plan as part of its 5 year Integrated Business Plan; assumptions for workforce changes, recruitment and retention within this project must align with the Trust's overall workforce plan.
- **Physical:** the existing accommodation is heavily occupied, making the splitting of the project into two phases an essential component of this project and the potential for disruption to the Trust organisation and infrastructure as a whole
- **Phasing:** difficult, and potentially reducing the ability to comply with national guidance
- **Timeliness:** the hospital will see continued pressure, both in terms of Urgent Care and ED attendances. From an operational perspective, the new facility must be ready as soon as practicably possible
- **Trust Transformation Programme:** Trust wide schemes for redevelopment of the Trust sites are all interdependent. This is the first scheme in a number of site-wide reconfiguration schemes.
- **Capital:** The project overall is dependent on the Trust securing the majority of capital through support from the NTDA
- **IM&T:** The project is dependent on the implementation of the Trust's Electronic Patient Record (EPR) project prior to opening.

3 | The Economic Case

3.1 Introduction

In accordance with the Capital Investment Manual and requirements of HM Treasury's Green Book (A Guide to Investment Appraisal in the Public Sector), this section of the FBC reaffirms the preferred option highlighted in the OBC. It reviews the changes in capital and revenue costs from the OBC and identifies reasons why the changes have happened and their impact on the position of the preferred option.

3.2 Estates Annex

An Estates Annex can be found at Appendix 2Q. This covers the design and technical aspects of the project in detail; including the phasing of the scheme, scope of works, design, programme and the guaranteed maximum price (GMP).

Summary of Construction Phases

The project comprises a new build Emergency Department and refurbishment of the existing emergency department to create a new medical assessment unit. Both the ED and medical assessment unit will have suitable adjacencies to ITU, Theatres and Base Wards.

The overall project is to be delivered in three phases:

- **Service Isolation / Diversion and Demolition:** part of the existing Victoria Building will be demolished to make way for the new build phase 1, including:
  - Moving substation 6 (currently serves A&E and Balmoral Building)
  - Moving substation 2 (currently serving Victoria Building)
  - Asbestos strip to service ducts
  - Isolation and diversion of services to ensure mains services are maintained to remaining buildings
  - Demolishing the Langham wing of the Victoria Building whilst ensuring connectivity and interfaces between remaining buildings
  - Demolishing St Luke's Chapel
  - Demolishing and de-commissioning mechanical plant areas adjacent to St Luke's Chapel
  - Demolishing the Link bridge from Jarvis

  During the demolition works the existing below ground services duct will be protected and maintained to ensure continuous operation of the adjacent building serviced by the site infrastructure running within these ducts.

- **Phase 1 New Build ED Construction**: construction of a new purpose built ED, extending over the current location of Car Parks A and B, the Langham Wing of Victoria Building and St Luke's Chapel to create a new building for the ED, including the following departments for both Adults and Paediatrics:
  - Initial Assessment

- Resuscitation
- Majors
- Minor Illness and Minor Injuries, Eye Casualty and Emergency ENT (MIaMIEE)
- Diagnostic Imaging

- **Phase 2 Assessment Refurbishment**: once the ED has moved from its existing location to the new build, the vacated area will be refurbished /remodelled to create the medical assessment and geriatric units. This area will include the following departments:
  - GP assessment area, acute medical clinics and ambulatory care centre (DVT & TIA)
  - RAU (Rapid Assessment Unit)
  - ACB (Acute care Bay)
  - EFU (Emergency Frailty Unit)
  - AFU (Acute Frailty Unit)

  Upon completion these areas will move from their current locations into this refurbished area.

3.3 Critical Success Factors

The critical success factors identified in the OBC remain appropriate and relevant for the FBC. These align to the investment objectives and key benefits criteria (Section 2.17).

Table 3.1 Critical Success Factors

No.	CSF	Explanation
1	**Quality**	To what extent does the option provide opportunities to deliver "Caring at its Best" by optimising the quality (clinical outcomes, safety and experience) of patient services provided during the transition period and in the future?
2	**Meeting Commissioners' intentions for healthcare services**	Does the option satisfy the existing and future anticipated models of care?
3	**Business Needs**	The preferred option satisfies the existing and future business needs of the Trust as described in the Strategic Case.
4	**Strategic Fit**	The preferred option provides a holistic fit and synergy with other key elements of national, local and Trust strategies.
5	**Value for Money (VFM)**	The option provides economies of scale, scope and efficiencies, whilst maintaining quality and standards of

No.	CSF	Explanation
		effectiveness in the delivery of care.
6	**Benefits Optimisation**	How well does the option optimise the potential return on expenditure – business outcomes and benefits (qualitative and quantitative, direct and indirect to the Trust) – and assist in improving overall VFM (economy, efficiency and effectiveness)?
7	**Potential Affordability**	Does the option satisfy the Trust's ability to innovate, adapt, introduce, support and manage the required level of change, including the management of associated risks and the need for supporting skills (capacity and capability)?
8	**Sustainability**	The Trust is confident in its ability to fund the required level of expenditure – namely, the capital and revenue consequences associated with the proposed investment.
9	**Achievability**	The preferred option provides the Trust with maximum flexibility to respond to continuously evolving healthcare provision, for example reducing its carbon footprint and modifying site capacity.

3.4 Determining the Capacity

3.4.1 Urgent Care Centre

The UCC contract is currently held by George Eliot NHS Trust. The impact of this contract being held outside of UHL has been modelled in the FBC I&E through the reductions in activity, consistent with CCG assumptions regarding the activity shift that will occur.

While the design has been based on the total activity figures (ED & UCC), the activity modelling in respect of a revenue position must exclude the UCC activity as it is not currently provided by UHL.

When the UCC contract is put to market, UHL will bid to provide this element of the emergency pathway but this has not been assumed in the FBC. The Trust believes that there are additional benefits, for example in workforce efficiencies, which could be realised if UHL was successful in their bid.

3.4.2 Activity

The Trust has undertaken extensive work as part of the Better Care Together (BCT) programme, projecting ED and Medical Assessment activity for the next 5 year period. This work has concluded that UHL will see a 7.8% reduction in ED attendances over the next 5 years. This reduction is not applied uniformly across all areas of the department as high acuity resus/ majors patients are not likely to be diverted from the acute hospital setting into community services. However lower acuity patients such as those with minor injuries or minor illnesses could be diverted and therefore this is where the reduction in overall activity will be achieved.

At the time of writing the Developed OBC (August 2014), the Trust's Long Term Financial Model (LTFM) was not aligned to the BCT planning assumptions, as the LTFM had been submitted to the NTDA prior to the release of the BCT information. Therefore the two activity projections were not aligned, and the NTDA agreed that the Developed OBC would reflect two activity scenarios. However, it was agreed with the NTDA and CCGs that work would be carried out in advance of the FBC to develop one model which aligned to the BCT programme.

The Trust's ED attendances have continued to increase during 2014/15 and consequently neither model proposed in the Developed OBC reflects a realistic way forward. Following discussions with the CCGs, a pragmatic approach has been agreed which uses the forecast outturn activity for 2014/15 as the baseline; and then applies the BCT assumptions over the subsequent 5 years using 2015/16 as year 1. Years 6-20 will follow demographic growth in line with the Office of National Statistics (ONS); 1% for ED and Clinic activity, 1.5% for medical assessment activity. This is the single model reflected in this FBC.

The agreed activity model (percentage and actual numbers) for the FBC is shown in the Tables 3.2 and 3.3 below. As above, this excludes UCC activity.

Table 3.2 FBC Scenario - Activity Percentages

	Baseline	Year 1 2015/16	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
ED	FOT 2014/15	-8.30%	1.60%	1.00%	0.00%	0.30%
Medical Assessment		-3.49%	-0.41%	-1.21%	-0.14%	0.24%
Clinic Activity		0.00%	1.00%	1.00%	1.00%	1.00%

Table 3.3 FBC Scenario - Activity Figures

	Baseline FOT 2014/15	Year 1 2015/16	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
ED	145,837	133,733	135,873	135,601	135,601	136,008
Medical Assessment	35,984	34,729	34,585	34,166	34,120	34,203
TOTAL	181,822	168,462	170,458	169,767	169,721	170,210

3.4.3 Capacity Assessment

The development of the brief for the new Emergency Floor has responded to changing baseline assumptions, a recognition of the operational constraints associated with emergency care, and the physical limitations imposed by a tight, inner-city site being redeveloped partially on a refurbishment basis.

Original Capacity Assumptions

The original briefing exercise underpinning the functional content of the new facilities and its design reflected a number of assumptions:

- 10-year planning horizon

- activity projections based on an analysis of demographic growth and historic trend growth
- use of 95th percentile hourly arrivals for ED streams, at 100% occupancy
- a one-off left shift of activity from the acute site to other settings, impacting on the UCC

To inform that exercise, an analysis was undertaken of recent emergency activity growth and the following key points were noted:

- in ED, recent trend growth had been on average 5% per annum, whilst demographic growth projected by the ONS for the ED population was approx. 1% (age-adjusted)
- For non-elective emergency admissions these figures were 3.5% and 1.5% respectively

To chart a mid-point between historic trend growth and ONS projected demographic growth, the following annual growth rates were used for the 10-year planning horizon:

- ED: average 3% per annum
- NEL/ medical assessment: average 2.5% per annum

The above parameters formed what was termed the Medium Scenario in the original OBC, and informed the capacity calculations used to scope the functional content of the scheme. Low and High Scenarios were also developed to reflect ONS-only and historic trend growth rates (i.e. 1% & 5% for ED activity, 1.5% and 3.5% for medical assessment activity).

The scheme was subsequently briefed and designed to reflect the functional content generated from the Medium Scenario assumptions, involving widespread consultation with clinical, managerial and support staff within and beyond the Trust, as well as patient representatives.

OBC Scenarios

Following the original brief, the Better Care Together programme released information about a health economy wide activity scenario for emergency care. This led to the OBC including two scenarios, as the Trust's LFTM did not align to the BCT assumptions at the time of writing. During the NTDA review of the OBC, it was agreed with the Trust that the Full Business Case would contain one activity scenario.

Scenario 1 New BCT Baseline - activity assumptions were:

- Use of 20-year planning horizon instead of 10-years
- Use of Better Care Together growth profile for years 1-5 of the projections
- Use of Office of National Statistics (ONS) population growth (1% as before) for years 6-20 of the model
- Use of 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

The New BCT Baseline assumptions impose a reduction in activity in the early years of the model due to the Better Care Together programme, and then a shallower, but longer, period of growth (i.e. to year 20, not to year 10). As a result of these two factors, the functional content determined by the new BCT demand & capacity model is marginally smaller than that scoped on the basis of the Medium Scenario parameters in the original business case.

Scenario 2 New LTFM Baseline - activity assumptions were:

- Use of 20-year planning horizon instead of 10-years
- Use of LTFM nil growth profile for years 1-6 of the projections
- Use of Office of National Statistics (ONS) population growth (1% as before) for years 7-20 of the model
- Use of 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

The new LTFM Baseline assumptions imposed nil growth in activity in the early years of the model due to the QIPP, and then a shallower, but longer, period of growth (i.e. to year 20, not to year 10). As a result of these two factors, the functional content determined by the LTFM demand & capacity model was still marginally smaller than that scoped on the basis of the Medium Scenario parameters in the original business case.

FBC Scenario

As advised by the NTDA, the FBC now uses:

- 20-year planning horizon instead of 10-years
- 85th percentile hourly arrivals for ED streams, at 85% occupancy, as per ECIST model

In addition the FBC also reflects:

- Use of FOT 2014/15 as the activity baseline, year 0
- Use of Better Care Together growth profile for years 1-5 of the projections
- Use of Office of National Statistics (ONS) population growth for years 6-20 of the model

The FBC Scenario assumptions impose a reduction in activity in the early years of the model due to the Better Care Together programme, and then a shallower, but longer, period of growth (i.e. to year 20, not to year 10). As a result of these two factors, the functional content determined by the FBC BCT demand & capacity model is smaller than that scoped on the basis of the Medium Scenario parameters in the original business case.

Impact of Revised Scenario

- The original functional content of the proposed scheme, based on a 10-year planning horizon, remains sufficient to meet the activity projected at year 20 under the new activity modelling.

- The original functional content has sufficient capacity to meet around 2% annual growth from years 6-20, should historic trends continue to be realised above the demographic growth of 1%.

This confirms that the originally proposed content and the design developed by the project team remain robust in the light of the FBC scenario assumptions. The slight capacity surplus in the proposed scheme is distributed across the project and its removal from the project would not warrant the cost, time and risk penalties associated with a full-scale redesign. This also provides future flexibility for the Emergency Floor.

However, it is recognised that in the early years of occupation of the new facilities there will be surplus accommodation as the BCT programme assumes a significant reduction of emergency activity at LRI in years 1-5. The scheme has been designed to be as flexible as possible through the employment, wherever practical, of generic clinical spaces. This would enable a range of services to backfill surplus accommodation in order to ensure that maximum utilisation is made of the new estate. Options include:

- Inclusion of the Surgical Assessment Unit in the Emergency Floor

Conversely, if future growth surpasses that modelled in the FBC BCT scenario (the impact of which might not manifest itself for 10-15 years), there are a number of initiatives that can be implemented in mitigation over time:

- Further work to understand and resolve downstream operational issues in the acute bed stock to help improve flow out of the emergency facilities generally
- The provision of additional critical care capacity (e.g. HDU, ITU) would similarly ease pressure on the Acute Care Bay and Resus
- The development control plan for the LRI site can include the further colonisation of adjacent space on the new emergency floor as alternative models of delivery are implemented for other clinical services
- The relocation of lower acuity workload (UCC and minors) to alternative location would liberate capacity within the proposed unit for higher acuity workload

The sensitivity testing of the demand and capacity modelling assumptions, and the strategies for coping with long-term upside and downside activity scenarios, have therefore confirmed the robustness of the original planning assumptions for the project. This provides assurance that the proposed investment offers the flexibility to deal with both changing levels and patterns of workload.

3.5 Options Appraisal

An options appraisal process was undertaken, as described in the OBC, which reduced a long list of 13 options to a short list of 4 options, and then identified a preferred option.

The short listed options were:

- **Option 0:** Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures

- **Option 1A:** Existing 1st floor refurbishment with some assessment provision elsewhere, (inc courtyard infill & extension)
- **Option 2C:** Demolition of Jarvis building & new build ED & refurbish assessment on single floor
- **Option 3A:** Demolition of Victoria building and part new build/part refurbish assessment on single floor

A qualitative benefits appraisal took place in October 2013, which included a weighting and scoring exercise based on the project objectives. One or more benefit criteria contribute towards each project objective; these criteria were scored (0-10).

The weighted scores and ranking for each option were as followed:

	Score	Rank
Option 0	2.26728	4
Option 1A	6.73794	2
Option 2C	6.28680	3
Option 3A	7.53636	1 – Preferred Option

Option 3A This option demonstrated through the non-financial appraisal process that the Trust is able to realise benefits and achieve strategic objectives and critical success factors of providing an appropriate solution to meeting current and future capacity demands for emergency care.

- This option lends itself to a detailed design process that provides essential departmental adjacencies
- Majors and Resuscitation areas can be located close to the front door and ambulances will have an ambulance only access to the department
- Adjacencies to the minor injuries and minor illness unit are enhanced and assessment services will maintain essential adjacencies within the department
- Paediatric emergency services demonstrated good adjacencies and separate paediatric entrance point is provided
- Ambulance access is provided on the same level as department entry which is essential for blue light access. The provision of an ambulance only access to the hospital department is seen as a better outcome to that which the other options can provide
- The single floor concept can be achieved with provision of diagnostics and assessment within the department and opportunities for flexibility and future proofing the design

In comparison to the other shortlisted options, the enabling moves associated with option 3A are deemed the least disruptive to the wider organisation with regards clinical

and non clinical operations, and are more aligned with the overarching vision for the site. Required relocations have been identified as follows:

- Urgent Care Centre
- Out Patient Clinics
- Fielding Johnson Ward
- Medical Physics & IM&T
- Multi Disciplinary Team Office
- Clinical Genetics OP Clinics and Clinical Skills Reception
- Chapel

This option provides an effective solution to the Trust's needs and in particular will be significantly more effective than the other options at providing flexibility, meeting capacity demands, enhancing the patient experience and emergency care pathway efficiencies. It also offers a solution with the least impact on the Trust's clinical and non clinical operations, DCP and strategic plans.

3.6 Economic Appraisal

3.6.1 Introduction

This section provides a description of the changes between OBC and FBC from a revenue and capital perspective. It discusses the impact of these changes on the validity of the OBC preferred option.

3.6.2 OBC options appraisal

The short listed options were:

- **Option 0:** Do Minimum - Ensure critical backlog maintenance is undertaken and review clinical processes & procedures
- **Option 1A:** Existing 1st floor refurbishment with some assessment provision elsewhere, (inc courtyard infill & extension)
- **Option 2C:** Demolition of Jarvis building & new build ED & refurbish assessment on single floor
- **Option 3A:** Demolition of Victoria building and part new build/part refurbish assessment on single floor

The OBC options appraisal can be summarised in the following table:

Table 3.4 Summary of Economic and Value for Money Appraisal

Criteria	Option			
	0	1A	2C	3A
Raw scores	51.18	131.74	129.64	148.71
Weighted Scores	2.27	6.74	6.27	7.54

Criteria	Option			
	0	1A	2C	3A
Rank (non-financial)	4	2	3	1
Net present cost (NPC) (£k)	1,264,890	1,222,633	1,220,895	1,223,981
NPC per point score (£k)	557,220	181,400	194,720	162,332
Rank (VFM)	4	2	3	1
Rank	**4**	**2**	**3**	**1**

The appraisal indicated a difference of 11.7% between the preferred option 3A and the next best option of Option 2A.

3.6.3 Estimating Costs

The FBC costs have been determined by Capita and the Trust's Cost Advisors, and are in accordance with NHS standards. The total capital costs for the preferred option at OBC stage and FBC stage are summarised below.

Table 3.5 Capital Costs at OBC & FBC

Capital Costs	OBC Stage (£)	FBC Stage (£)
Construction	30,233,828	32,489,899
Fees	6,781,406	5,614,257
Non Works Costs	0	76,021
Equipment	1,692,000	2,403,206
Planning Contingency	2,894,644	2,495,893
Total for approval purposes	41,601,878	43,079,276
Optimism Bias	0	0
Inflation	389,840	924,489
Total	41,991,719	44,003,765
VAT Recovery	-649,792	-674,738
Grand Total	**41,341,927**	**43,329,027**

The main assumptions in the above figures are

- The costs at FBC are based on the contract price (GMP) plus non GMP items as set out in the FB cost forms in Appendix 3A, 3B, and 3C
- VAT has been included at 20% where it is generally applicable although the intention is to continue to work with VAT advisers to identify elements of the costs for which recovery can be made.

3.6.4 Compliance with Capital Cost Thresholds

If the capital cost exceeded 5% of the costs stated and approved in the OBC (£41.6M) there would be an automatic lapse of approval of the OBC. As can be seen in the table above, the total for approval purposes has increased for £41.6M to £43M. This is an increase of £1.4M which is 3.5% when compared to the £41.6M approved at OBC stage and within the tolerances allowed.

3.6.5 Changes since the OBC

There have been no major design changes since the OBC.

The key changes to the construction costs have been as a result of market testing in which many of the works packages are priced higher than forecast. As a result of this the Trust undertook a value engineering exercise

In addition there has been an increase in equipment costs of c£700k as a more detailed review of equipment needs was undertaken. In line with normal practice at OBC stage the equipment cost were based on a % of the works costs and abated for transferred items. The assumption at OBC stage was a 40% transfer. However the detailed equipment work has indicated a transfer of c15% of equipment. The more detailed design undertaken for FBC stage has also identified additional cost in respect of group 4 items (small trust supplied items) and IT requirements.

Additional costs have also been included for works to existing highways since as part of the planning approval the Trust has been required to carry out section 278

Since the Developed OBC the Trust has also identified £1.3M worth of fees included at the Developed OBC stage that were not part of this project, but part of a previous iteration of developing an OBC that didn't progress. The Trust has now funded this from its own internal resources. As the costs do not relate to the current scheme and the Trust is not seeking funding this cost has therefore been removed.

Non works costs of c£76K have been identified as the Trust needs to relocate a bed store in order to provide space for a new substation. The bed store in turn is moving into the site of the Knighton St museum which in turn is relocating to the Glenfield site.

Routes to Affordability Exercise

A review of the design vs outturn cost identified an increase in capital cost. To mitigate this, a 'Routes to Affordability' exercise was undertaken to provide a leaner solution for the scheme that still delivered the clinical functionality of the original intended design. The delivery team including UHL, RLB, ICL and technical advisors reviewed the overall project design including Phase 1 and Phase 2 and produced a summary of

opportunities to deliver savings. These were then rated in agreement with the Trust in preference based on perceived impact to the scheme and saving level.

During the Routes to Affordability exercise, budget values were then agreed for each item whilst high level design impact assessments were carried out. Instruction was received from the Trust to incorporate only the viable items. Where savings have been realised these have been incorporated into the GMP value.

The Phase Two refurbishment works for assessment were designed and market tested on the basis of a full strip out to shell and new finishes and services throughout. The total cost plan allowance excluding VAT amounts to an allowance of £1,970/m^2. This was not an efficient approach to the design solution and did not represent value for money.

With the confidence of benchmarking, the team have been tasked with re-designing the area to use existing structure and services where possible, in line with the budget which has been allowed at £1425/m^2. For example, the Emergency Decisions Unit can stay in its existing location which delivers a leaner capital scheme, while still providing the required clinical functionality.

This review will be based on a set of updated operational policies which reflect the new GP assessment processes, and the need for the Emergency Frailty Unit and the Acute Frailty Unit to be in the same space to allow workforce efficiencies.

Therefore, capital costs include a provisional sum for the Phase Two works which will drive the design solution to an achievable budget for the type of refurbishment works required (£1425/m^2).

More detail can be found in the Estates Annex at Appendix 2Q.

3.6.6 Guaranteed Maximum Price

The agreed Guaranteed Maximum Price (GMP), which includes inflation and VAT, of Interserve Construction Limited, the Principal Supply Chain Partner (PSCP), for the design and construction of the Emergency Floor at Leicester Royal Infirmary includes all of the costs to date, in addition to all anticipated costs in completing the design and construction of the facility.

The GMP offer made by Interserve in 2014 is based on a construction start date of July 2015. Interserve have confirmed work must start within the following 3 months to ensure the GMP remains the same. However the impact of not achieving this date will result in a delay, creating additional costs. The GMP offer can be found at Appendix 3D.

The OBC included inflation which was based on industry standards. This FBC includes market tested costs which reflect a fixed price for construction. Risk of inflation sits with Interserve Construction Ltd., our construction partner.

The total project capital cost is £43.3m and this is broken down into a number of elements (including the GMP) as set out in the table above and in the FB forms which can be found at Appendix 3A, 3B and 3C.

3.6.7 Risks

Planning Contingency Comparison

Table 3.6 below shows that the value of risk included in costs has decreased as certainty of the project has developed and detailed designs have been developed.

Table 3.6 Risk Summary

Risk Costs	OBC Stage (£)	FBC Stage (£)
Planning Contingency (Trust)	1,518,484	1,242,600
PSCP risk	1,376,160	1,253,293

The risk register (Appendix 2T) has been reviewed and covers all known issues including costs. The value includes current knowledge regarding planning conditions and it is important to note that a separate allowance has not been made for optimism bias.

Key risks that have been identified are primarily due to the fact that the works take place on a live hospital site and the fact that the scheme is a mixture of existing and new buildings. Examples of the risks include:

- Accidental damage to existing buildings during demolitions
- Accidental damage to existing buildings during construction
- Discovery of contamination or high water table
- Architectural/design issues in existing buildings
- Unplanned Trust stoppages to works

3.6.8 Revenue Costs

The revenue changes in the OBC have been reviewed and worked up in more detail. The following table reflects the position at OBC:

Table 3.7 OBC Revenue Costs

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Income change	(1,600)	(1,331)	(1,386)	(1,349)	(1,246)
Expenditure					
Agency	0	0	738	738	738

Workforce efficiencies	0	0	828	828	828
Other efficiencies	0	0	900	1,600	1,600
Pay and non pay increases from additional activity	0	(40)	(32)	(38)	(53)
Facilities	0	0	(165)	(165)	(165)
Depreciation	0	85	(559)	(774)	(774)
Rate of return	0	45	(957)	(945)	(921)
Transitional funds	1,600	1,250	650	100	0
Total change in expenditure	1,600	1,340	1,403	1,344	1,253
Total Net Change	0	9	17	(5)	7

This showed a circa breakeven position when income and capital charges are accounted for. The net savings on expenditure (not including capital charges) were £2.9 million in 2018/19. This was counterbalanced by a loss of income of £1.2 million and net additional capital charges of £1.7 million.

The revised position as per the FBC is as follows:

Table 3.8 FBC Revenue Costs

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Income change	**1,386**	**239**	**263**	**(80)**	**(127)**
Expenditure					
Agency	0	840	1,844	2,347	2,347
Workforce efficiencies	0	356	626	1,373	1,373
Additional clinical costs from new development	0	0	(183)	(734)	(734)
Additional maintenance costs of equipment	0	0	(58)	(271)	(383)
Pay and non pay increases from changes in activity	0	320	332	378	379
Depreciation	177	177	(25)	(637)	(637)

Rate of return	45	(334)	(686)	(720)	(698)
Total change in expenditure	**222**	**1,360**	**1,851**	**1,736**	**1,646**
Total Net Change	**1,608**	**1,599**	**2,114**	**1,656**	**1,520**

The net position is significantly better as a result of revised assumptions on income loss. In the Developed OBC the Trust had assumed a reduction in ED income of 7.8% equating to an activity loss of 7.8%. The Trust has reviewed this and whist still assuming a 7.8% activity loss, has assumed that the reduction in income will be 3.7% as the CCG's efforts will focus on the more inappropriate use of the ED, reflecting lower acuity patients.

Savings on expenditure (excluding capital charges) are £3 million in the FBC, representing an increase in savings of £34k. The main reasons for the change in savings result of a detailed review of the EF cost base and related costs. A detailed workforce planning exercise has been undertaken to identify all clinical savings relating directly to ED. As part of this exercise additional costs have been identified in clinical support services to support the new model of care. These have been offset to a large extent by the additional savings within the Emergency Floor itself, and a revised view on the implications on FM of the Emergency Floor.

The Revenue cost position therefore has only marginally changed and is within the parameters set by the Capital Investment Manual and the TDA guidance/ checklist.

3.6.9 Summary of Position compared to OBC

The changes between OBC and FBC are as follows:

	OBC	FBC	Comment
Capital Costs	£41,342k	£43,329k	Driven by additional equipment market testing and s278 works re highways
Annual Revenue Costs (2018/19)	£44,580	£44,583	Driven by changes in activity, additional costs of equipment maintenance partially balanced by reductions in capital charges in FM costs

3.7 The Preferred Option – Option 3A Victoria

The FBC continues to show:

- Significantly improved patient environment and facilities
- Significant reduction in risk
- Enhanced operational efficiencies

- Majors and Resuscitation areas can be located close to the front door and the ambulances will have ambulance only access to the department
- Adjacencies to the minor injuries and minor illness unit are enhanced and assessment services will maintain essential adjacencies within the department
- Paediatric emergency services demonstrated good adjacencies and separate paediatric entrance point is provided
- Ambulance access is provided on the same level as department entry which is essential for blue light access. The provision of an ambulance only access to the hospital department is seen as a better outcome to that which the other options can provide
- The single floor concept can be achieved with provision of diagnostics and assessment within the department and opportunities for flexibility and future proofing the design

Consequently and for the reasons set out in the sections above this remains the preferred option.

Option 3A provides an effective solution to the Trust's needs and in particular will be significantly more effective than the other options at providing flexibility, meeting capacity demands, enhancing the patient experience and emergency care pathway efficiencies. It also offers a solution with the least impact on the Trust's clinical and non clinical operations, DCP and strategic plans.

Please see Appendices 3E to 3Y for 1:200 and 1:50 scale plans, palette of construction materials, roof plan and external visualisations for the preferred option.

3.7.1 Evolution of the Schedule of Accommodation

A series of schedules has evolved in parallel with the design development of the preferred option and a copy of the current version 18 is attached in full as Appendix 3Z.

The first column references national guidance and provides a measured space in m^2 against HBNs where available. The next column denotes that briefed by the clinical planner and is an assessment of the functional area required to deliver the service against the agreed clinical model and supporting activity and capacity model. To this area allowances are added for planning provision, engineering and general circulation, and are referred to as brief uplift. This is then totalled to give the overall departmental area. The final columns denote that scheduled and drawn by the architect post further liaison with the clinical teams, culminating in a final measured area that allows for wall/ partition thicknesses and is that used for costing purposes.

Where the design has been constrained and HBNs and other national guidance has not been adhered to, the schedule details a brief explanation with regards the derogation and associated reasons, which in all cases has been supported by the relevant Trust clinical and managerial leads. Functionality of the spaces has been tested through a series of mock-ups, simulation tests and benchmarking against other facilities.

As a result of NTDA (Project Assurance Unit) concern at OBC stage regarding the derogated rooms, the Trust has appointed an independent ergonomics assessor to

review the functionality of specific rooms. The outcome of this is that there are 2 specific room types that need to be reviewed to ensure complete clinical functionality. These are the initial streaming rooms, and the assisted toilet / shower rooms. The design will be reviewed in January; the impact is not deemed to be material.

4 | The Commercial Case

4.1 Introduction

This section of the FBC outlines the proposed procurement strategy in relation to the preferred option outlined in the Economic Case.

4.2 Procurement Strategy

The scheme will be procured through UHL's framework partnership with Interserve FM and assigned to Interserve Construction Limited.

Under the bespoke framework, Interserve Construction Ltd is appointed as principal contractor for the delivery of projects; commercial arrangements and contracts are pre-agreed to cover commissioning of the business case through to final delivery of the asset using an NEC3 Option C Form of Contract (Target Contract with Activity Schedule). Cost savings are split between the Trust and the Client based on previously agreed percentages which will engender a spirit of partnering and collaboration within the Project Team. The risk of cost overrun is transferred to Interserve once the GMP has been agreed and construction stage commenced.

Project risk is dealt with openly from the outset of the project and the client; Interserve and the Design Team are encouraged to take an active role in identifying, mitigating and apportioning risk to the party best suited to deal with it. This should be a proactive process throughout the delivery of the project.

Key external advisors and construction services are as follows:

Table 4.1 Key External Advisors & Construction Services

Role	Organisation
Pre-construction	
Business case preparation	Capita
Mechanical and electrical consultants	Capita
Architects	Capita
Structural engineers	Capita
Cost consultants	Capita
CDM	Capita
Project management & cost advisors	RLB
GMP development	Interserve Construction Ltd
Construction	
CDM	Capita
Project management & cost advice	RLB

Building contractor	Interserve Construction Ltd
MEP Detailed Design & Installation	Interserve Engineering Services

Under the framework, Interserve has:

- Taken single point responsibility to manage the design and construction process from completion of OBC through to project completion
- Assembled a dedicated team from its supply chain of experienced health planners, designers and specialists, to successfully deliver facilities that will benefit patients and staff alike
- Provided benefits of experience of long term partnering arrangements that will continue throughout the life of the project
- Committed to identifying construction solutions that will assist in the implementation of improved service delivery, best practice and delivering best value

Interserve and UHL have worked together through the full business case (FBC) stage to develop and agree a guaranteed maximum price for delivery of the scheme. This reflects:

- Fees for professional advice such as design and cost management
- Market tested packages for construction works on an open book basis

The GMP has been assessed for overall value for money by cost consultants acting for UHL (Rider Levett Bucknall - RLB). This will take into account elements such as:

- Prevailing rates for similar works nationally and locally
- Published cost indices
- Knowledge of the cost of work in the hospital from other recent schemes
- Prime contractor and client retained risks as identified in the joint risk register

It was agreed that the development of the GMP would be run in parallel with the development of the Works Information and this would be undertaken in a fully open book / collaborative environment, such that a minimum of three quotations would be obtained for all Works Packages making up at least 80% of the GMP.

Package responses were assessed by Interserve Construction Ltd in conjunction with the Trust's advisors RLB to ensure the 'Best Value' tender was included in the GMP. The assessment was not only be based on price but also programme, design/ technical proposals and likely risk. Interserve and RLB agreed a formal assessment proposal for each package. Tenders were benchmarked appropriately.

Should the scheme not proceed, the Trust will own the design at point of termination but will be liable for Interserve costs up to that point, in line with contractual commitments made during commissioning of the project.

4.3 Key Factors Affecting Outcomes

4.3.1 Planning Permission

The preferred option requires planning consent, which was obtained on 24th September 2014 subject to Planning Conditions. Appendix 4A shows the Planning Approval and Planning Conditions; Appendix 4B shows the Planning Conditions Tracker.

Planning Preparation Process

Initial enquiries about the implications of extant planning policies were made by telephone to Leicester City Council (LCC) Planning and Conservation officers during the options appraisal period. Once the preferred option was agreed, a formal meeting was held on 19th December 2013 to discuss potential issues and to agree upon an approach for on-going dialogue.

It was agreed that a two-weekly cycle of progress meetings should be held up to the submission of the application. It was anticipated that the process of dialogue would be iterative and that the broad structure of discussion at each meeting would focus upon:

- Matters arising in the previous three weeks and actions taken thus far to resolve them
- LCC feedback on any draft reports and/ or other relevant material provided to them at an earlier meeting and/ or sent to them in between meetings
- Identification of issues requiring further action
- Progress in terms of resolving identified problems
- General progress towards submission of an application

A key aim of this programme of meetings was to ensure, as far as reasonably possible, that obstacles and problems were identified and resolved before the application was submitted and that there were no unknown factors at the point of submission. A Planning Programme, forming part of the overall Project Programme, was prepared in response to this objective. The Programme incorporates the agreed schedule of meetings with LCC officers (and other stakeholders) and, for each meeting, defines the intended deliverables in terms of design development details and projected dates for completion of technical reports, to enable LCC to review and provide feedback in advance of the denoted application submission date of 2nd June 2014.

This structure worked well, and at LCCs request, it was agreed that meetings continue after the application was submitted for determination to ensure:

- That issues arising as a consequence of formal consultation can be fully aired and considered
- That any request for additional information is explained and understood so that a response can be provided promptly
- That everything practical is undertaken to enable the planning application to be determined within the 13 week target period

The 13 week target date for determination of the application started once the application had been formally registered as valid. LCC Planning had alerted the Trust

and project team in advance that there was a possibility of issues arising that would result in the 13 week target date for determination not being met. LCC also explained the importance of ensuring that the application was put before the Planning Committee in order to maximise the likelihood of a positive outcome, even if this meant that the 13 week target was not met.

Key Planning Issues

Planning consent for this project depended upon the strength of case that was presented to address key planning policies that are directly relevant to these proposals. Conservation issues are especially pertinent in view of the fact that the proposal:

- Requires the demolition of a Victorian Chapel (St Luke's) which is locally listed
- Will affect the setting of the Victoria 1771 building which is a Grade II statutorily listed building to be retained

It was acknowledged early on that the heritage lobby could raise issues that would affect the timescale for the submission and determination of the application. As a result, the significance of the heritage issues was a key driver in terms of the focus of discussion with LCC Planning and Conservation officers, and a programme of engagement with heritage organisations was undertaken over a number of months. Prior to the submission of the Planning Application, English Heritage confirmed receipt of an application to list the chapel, which was turned down.

Prompted by concerns in the press, the Chair of LCC's Planning Committee invited the Trust to give a presentation on the reasons underpinning the development proposals and why alternative options (which would not impact upon heritage assets) have been dismissed. The presentation took place on 29th January 2014 and gave Members an opportunity to ask factual questions, albeit they were cautioned by the Head of Planning that they should not express an opinion at this stage.

Letters were sent to representatives of the Leicester branch of the Civic Trust, the Leicester Victorian Society, the County and Rutland 'At Risk' War Memorials Project and the Leicestershire Archaeological and Historical Society to inform them personally about the plans the Trust is developing for the new Emergency Department and the clinical reasons underlying the proposed development. The letters made it clear that the Trust would be happy to arrange separate meetings with each organisation to discuss further the issues and the proposed solution.

A further presentation was given to members of the Conservation Advisory Panel (CAP) at a meeting on 12th February 2012. The meeting was arranged by LCC who provide secretariat support for CAP. A site visit for members preceded the meeting and was well attended, enabling individuals to gain a visual understanding of the proposals and their impact. Engagement with the heritage organisations continued up to the point of the planning application submission, as necessary.

A second presentation to the CAP, held on Wednesday 18th June, resulted in a positive outcome where the panel agreed the project was a key requirement for the city and that the current design complemented 18th century architecture and the buildings that will be adjacent to the development.

The Heritage Consultant advising the Trust and project team liaised closely with LCC's Conservation Officer to establish the scope and structure of information to be incorporated into a Heritage Strategy which LCC required as part of the documentation to be submitted in support of the application. The strategy sets out the approach to the management and maintenance of the heritage assets affected by the development proposals, including both St Luke's chapel and the listed building. It also addresses the factors that have informed the development of proposals for the new A&E and the criteria that has underpinned the option appraisal process.

LCC emphasised the need to demonstrate the Trust's commitment to the retention, care and reinstatement of the artefacts from St Luke's chapel and the interim and longer term intention to make provision for a Christian chapel and spiritual care centre. The strategy also explains how the design of the new building has taken into account the setting and character of the listed building, both in terms of the design of the new building and the manner in which the current green space will be treated and managed.

Discussions with the City Archaeologist were also carried out to assist in defining the nature of pre-construction evaluation and investigative work which may be necessary.

Highways & Parking

Issues with regard to traffic movements, including agreement on arrangements for 'blue light' access into and out-with the site, have been the subject of very constructive meetings with officers at LCC Highways.

Car parking matters, including temporary solutions, have also been discussed in detail. The 256 staff parking spaces lost from the LRI site have been offset by provision at a nearby multi storey car park to allow for the proposed development.

It has been agreed with the LCC Highways department for the project to submit both section 184 and 278 applications to cover the use of the proposed point of access/ egress during and post construction.

Planning Approval

The requirement to achieve Full Planning Approval ahead of FBC submission has been achieved. In addition, the Trust were made aware that English Heritage had confirmed it is not their intention to list the chapel or any other parts of the proposed areas for demolition.

4.3.2 Building Research Establishment Environmental Assessment Method (BREEAM)

BREEAM is the leading and most widely used environmental assessment method for buildings and communities. It sets the standard for best practice in sustainable design and has become the de facto measure used to describe a building's environmental performance. BREEAM provides clients, developers, designers and others with the following:

- Market recognition for low environmental impact buildings
- Assurance that best environmental practice is incorporated into a building
- Inspiration to find innovative solutions that minimise the environmental impact

- A benchmark that is higher than regulation
- A tool to help reduce running costs, improve working and living environments
- A standard that demonstrates progress towards corporate and organisational environmental objectives

BREEAM addresses wide ranging environmental and sustainability issues and enables developers and designers to prove the environmental credentials of their buildings to planners and clients. It:

- Uses a straightforward scoring system that is transparent, easy to understand and supported by evidence-based research
- Has a positive influence on the design, construction and management of buildings
- Sets and maintains a robust technical standard with rigorous quality assurance and certification

The project team have worked alongside an accredited BREEAM assessor throughout the design process to ensure requirements are considered in a timely manner. The project has been awarded an Interim Certificate – Design Stage by the BRE showing a score of 56.2%, reflecting a Very Good rating. See Appendix 4C for the Interim Certificate.

4.4 Potential for Risk Transfer

The LLR Framework has a single comprehensive risk management process, which the Trust will be using (see Section 6.8 for details). The Emergency Floor Project Senior Responsible Officer (SRO) and Interserve act as joint owners of the joint project Risk Register for this scheme, responsibility for risks identified in it are then to be allocated and identified on the associated risk register. The risk of cost overrun is transferred to Interserve once the GMP has been agreed and construction stage commenced.

4.5 Proposed Charging Mechanisms

The Trust intends to make payments in relation to works required in accordance with the LLR Framework Agreement. The NEC Option C Form of Contract will be the agreed form of Building Contract for Interserve works. The Building Contract stipulates the payment mechanism, timescales, method of payment calculation etc.

Charging mechanisms approach applied relates to Interserve Construction Ltd being paid the Defined Cost of the works plus their fee up to the GMP. Under the current contract there is a mechanism for a Gain Share whereby if the final costs are below the GMP then there is the potential for both the Trust and Interserve Construction Ltd to share the savings, generally on a 50/50 basis if the final cost is up to 5% less than the GMP; if the final cost is more than 5% lower than the GMP then the client retains 100% of the savings below the 95% level (if the final cost exceeds the GMP then there is no additional cost to the Client, unless instructed otherwise). This in turn incentivises efficient working and elimination of unnecessary cost.

4.6 Proposed Contract Lengths

Contract lengths will be set in relation to the Trust requirements and the advice of Interserve Construction Ltd.

4.7 Proposed Key Contractual Clauses

Key contractual clauses in relation to works associated with this scheme will be in accordance with LLR Framework contract terms; namely the NEC Option C contract which contains core clauses and Secondary Z clauses specific to the Framework route and bespoke requirements of the Client.

4.8 Personnel Implications (including TUPE)

TUPE Regulations will not apply to this investment as no undertakings will transfer between employing entities.

4.9 Procurement Strategy & Implementation Timescales

Section 6 of this business case outlines the implementation programme.

The Project Programme is intended to deliver the project by summer 2017, though this timeline is predicated on the early works being commenced in parallel with development of the Full Business Case.

The Trust Board and NTDA should have assurance with this approach as the majority of enabling and associated demolition works sit comfortably with the future Development Control Plan for the LRI site.

4.10 Equipment Strategy

The Trust intends to implement an equipment strategy that incorporates the following:

- Ownership of the majority of equipment
- Some equipment leased e.g. beds and trolleys leased under the bed management contract
- Larger imaging equipment within the ED will be included within the Trust's Managed Equipment Service (MES) contract e.g. diagnostics/ imaging

The equipping manager has followed a robust methodology in order to ascertain what equipment can be transferred from the existing Emergency Floor departments, and what needs to be purchased either via capital or revenue funding.

The Room Data Sheets and Bill of Quantities were used to ascertain the equipment requirement of the new Emergency Floor, as these highlight the specifications and dimensions needed for equipment. An audit was undertaken of all clinical areas that are due to move into the Emergency Floor, which gave an overview of what would be fit for transfer and also have asset life when transferred. A significant element of the equipment currently utilised is still fit for purpose and has been identified for transfer.

Appendix 4D shows the equipping schedule of items to be purchased via capital funding. Appendix 4E shows the equipping schedule of items to be purchased via revenue funding, utilising the Trust's current contracts.

Assumptions have been made that the following will be used:

- **Asteral, Managed Equipment Service** - fixed equipment for Imaging Suite and mobile imaging equipment
- **Interserve Soft FM services** - all cleaning equipment
- **Bed Management Contract** - beds, trolleys, couches and high-back bedside patient chairs
- **Empath service** - Hot lab equipment

Other considerations were also taken into account in determining the equipment schedule. These included:

- **Standardisation of Equipment** - the Trust has standardised an element of its equipment base. In terms of commercial leverage and more importantly clinical safety, equipment will be purchased in line with these standardised ranges.
- **Utilisation of Trust's current strategic contracts** - the Trust has in place a number of long standing contracts, e.g. bed management and imaging diagnostic equipment, which are both covered by Managed Service arrangements and these will be utilised at the point of purchase. Other legacy contracts were also utilised in the costing exercise.
- **Information Technology** - the Trust is working with its Managed Business Partner IBM and their network support partner NTT. The process has also included an analysis of the technology requirement both in terms of actual equipment and infrastructure.
- **Pathology** - Empath have provided their professional assessment in determining the hot lab requirements, taking into account the needs of the ED service and Empath operating service model.
- **Medical Physics** have provided information from their equipment data AIMS and technical support from the Medical Physics ED technician.
- **Stakeholder Engagement** - meetings have taken place with key stakeholders in the Emergency Department including lead clinicians. At the initial meeting, it was agreed that the equipping officer should meet with constituent sections with ED to determine their requirements and to understand the footprints of the equipment required.
- **Appropriate suppliers** in the market have provided information on specification and price. Pricing information has also been obtained from local and nationally convened contracts available for use by the Trust

4.11 Financial Reporting Standard 5 Accountancy Treatment

Assets underpinning delivery of the service will be reflected on the Trust's balance sheet.

5 | The Financial Case

5.1. Introduction

The purpose of this section is to set out the forecast financial implications of the preferred options as set out in the Economic Case and the proposed deal (as described in the Commercial Case).

The Trust was formed in April 2000 and the financial results show that the Trust made a surplus of £0.1m for both 2011/12 and 2012/13 and a £39.7m deficit in 2013/14.

The short listed options have undergone a rigorous level of scrutiny as far as practicably possible for this stage in business case proceedings, and have proved to be robust in terms of the delivery of significant clinical benefits. It is now important to ensure that these options will be affordable to the Trust and will remain so.

5.2. Capital Costs

The capital costs of the preferred option total £43.3M including forecast out-turn inflation. Below is an analysis of the total costs.

Table 5.1 Summary of Capital Costs

Capital Costs	Option 3A Victoria (£)
Construction	32,489,899
Fees	5,614,257
Non Works Costs	76,021
Equipment	2,403,206
Planning Contingency	2,495,893
Sub Total	43,079,276
Optimism Bias	
Inflation	924,489
Total	44,003,765
VAT Recovery	-674,738
Grand Total	**43,329,027**

5.3. Financing

The table below sets out the cashflow associated with the scheme together with sources of funding. This shows that the Trust has clearly identified its capital requirements and has also identified relevant sources of funding.

As can be seen below the Trust has currently funded the initial development costs from its own resources but is seeking funding for the full costs of the scheme. Further details to support these figures are within Appendix 5A.

Table 5.2 Sources and Applications of Funds

	2013/14 £	2014/15 £	2015/16 £	2016/17 £	2017/18 £	2018/19 £	TOTAL £
Capital Expenditure	568,764	6,368,024	17,698,095	18,341,114	1,027,768	-674,738	**43,329,027**
Funded By							
PDC/Public Loan			24,634,883	18,341,114	1,027,768	-674,738	**43,329,027**
Trust Resources	568,764	6,368,024	-6,936,788				**0**
Total Funding	568,764	6,368,024	17,698,095	18,341,114	1,027,768	-674,738	**43,329,027**

5.4. Income & Expenditure

As discussed earlier in the business case the Trust has undertaken a review of future demand within the UHL ED. The agreed activity model percentages for the FBC are shown in table 5.3 below.

Table 5.3 Activity Assumptions

	Baseline	Year 1 2015/16	Year 2 2016/17	Year 3 2017/18	Year 4 2018/19	Year 5 2019/20
ED	FOT 2014/15	-8.30%	1.60%	1.00%	0.00%	0.30%
Medical Assessment		-3.49%	-0.41%	-1.21%	-0.14%	0.24%
Clinic Activity		0.00%	1.00%	1.00%	1.00%	1.00%

Within the first five years, activity levels are predicted to fall from the 2014/15 baseline based on the assumption of implementation of Better Care Together (BCT) Plans to divert attendances from ED to alternative providers of care in both primary and community settings. This represents an increase from the 2013/14 level of income in 2014/15 and smaller increases in 2015/16 and 2016/17 until the implementation of BCT plans reduce income compared to 2013/14.

It is anticipated that after this point there will be a small increase in activity driven by changes in demographics and acuity levels. This initial decrease in activity will impact on staffing and non pay costs. These shifts in activity by type have been modelled and will be used to calculate the most appropriate staffing levels taking into account the risks of a 'boom and bust' approach to workforce planning given the lead in times for education and training.

Table 5.4 shows a summary of the impact of these assumptions on the Trust's I&E over the first 5 years. More detailed information on impact can be seen in Tables 5.5 and 5.6 below.

Table 5.4 5 Year Financial Summary

	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Income change	**1,386**	**239**	**263**	**(80)**	**(127)**
Expenditure					
Agency	0	840	1,844	2,347	2,347
Workforce efficiencies	0	356	626	1,373	1,373
Additional clinical costs from new development	0	0	(183)	(734)	(734)
Additional maintenance costs of equipment	0	0	(58)	(271)	(383)
Pay and non pay increases from changes in activity	0	320	332	378	379
Depreciation	177	177	(25)	(637)	(637)
Rate of return	45	(334)	(686)	(720)	(698)
Total change in expenditure	**222**	**1,360**	**1,851**	**1,736**	**1,646**
Total Net Change	**1,608**	**1,599**	**2,114**	**1,656**	**1,520**

The following revenue consequences have been worked through in some detail since OBC. The key elements of the workforce plan are discussed in detail in the workforce

section. In summary the changes in income and expenditure are shown in the following table. Further details to support these figures are within Appendix 5B.

Table 5.5 Changes in Income & Expenditure

Area	2018/19 Savings £'000	Comment
Income Loss	(127)	The Trust has reviewed the income loss resulting from the reduced activity, principally the 8.3% reduction in ED attendances and 3.49% in medical assessment activity in 2015/16. It is expected that the commissioner's schemes for diverting inappropriate activity away from ED will have an impact on activity attracting the lower tariff. As a result the income loss has been reassessed and reflects a reduction of £127k per annum
Expenditure		
Agency staff	2,347	As a result of the EF development, the Trust is looking to significantly reduce the premium rates it pays as a result of filling vacancies. The majority of this (£1.9 million) relates to nursing staff. With a further £0.4m on Medical staff. The target savings are based on achieving a figure of 5% of budget spent on premium rates
Clinical Workforce Model Changes	930	The Trust has reviewed the impact of a reduction in activity on the department and also reviewed shift patterns to work in the new emergency floor.
Nursing savings from co locating UCC and Emergency Floor	211	The Trust has estimated the benefit of efficiencies gained in co locating the UCC with the Emergency Floor. This will need to be confirmed with the CCG in respect of the how the UCC will be procured in the future
Non clinical workforce changes	230	As a result of co locating UCC and the emergency floor, the Trust has identified savings in reception and portering staff
Clinical support costs	(734)	As a result of providing dedicated hot lab and radiology facilities to the emergency floor, there is an additional requirement for radiology and pathology staff. This will give additional capacity which will allow the Trust to deliver additional activity in the future at a lower marginal rate
Equipment	(383)	The Trust will look to use existing MES and bed

revenue costs		contracts to service additional requirements for beds and medical equipment. In addition to this it has assumed that it will incur maintenance costs for 75% of the Capital equipment assumed
Pay and non pay increases from changes in activity	379	Projected pay and non pay costs for 15/16 onwards have been varied in line with activity movements.
Capital Charges	(1,336)	The additional capital charges have been based on an impaired capital cost. The impairment relates to the costs of demolition and refurbishment and Trust fees

The Trust has also allowed for the cost of running 5 additional Acute Frail elderly beds. These beds will support commissioners in reducing emergency admissions and are part of the infrastructure that is required to deliver the changes in activity proposed by Better Care Together. The Trust will seek to secure additional funding from commissioners through BCT to develop this model.

Table 5.6 20 year scenario Income and Expenditure

FBC Scenario Income & Expenditure	2014/ 15	2015/ 16	2016/ 17	2017/ 18	2018/ 19	2019/ 20	2020/ 21	2021/ 22	2022/ 23	2023/ 24	2024/ 25	2025/ 26	2026/ 27	2027/ 28	2028/ 29	2029/ 30	2030/ 31	2031/ 32	2032/ 33	2033/ 34
Income																				
ED Tariff	16,090	15,260	15,504	15,473	15,473	15,520	15,520	15,675	15,832	15,990	16,150	16,312	16,475	16,639	16,806	16,974	17,144	17,315	17,488	17,663
Medical Assessment Unit	14,726	14,409	14,189	13,877	13,830	13,849	13,989	14,155	14,322	14,492	14,664	14,838	15,014	15,192	15,372	15,555	15,740	15,927	16,116	16,308
Other Income (RTA, Teaching etc.)	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402	4,402
Total	**35,218**	**34,071**	**34,095**	**33,752**	**33,705**	**33,771**	**33,911**	**34,232**	**34,556**	**34,884**	**35,216**	**35,551**	**35,890**	**36,233**	**36,580**	**36,931**	**37,285**	**37,644**	**38,007**	**38,373**
Expenditure - Pay																				
Nursing	13,365	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212	13,212
Nursing Agency	1,406	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390	1,390
Medical Staff	12,798	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652	12,652
Medical Locums	1,059	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047	1,047
A&C	1,066	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054	1,054
Healthcare Assistants	793	784	784	784	784	784	784	784	784	784	784	784	784	784	784	784	784	784	784	784
Reduction in Agency Costs	-	(840)	(1,844)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)	(2,347)
Workforce efficiencies	-	(356)	(356)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)	(361)
Workforce efficiencies ref New ED Floor	-	-	(270)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)	(1,011)
Additional Staffing Costs - Growth Increase	-	-	-	-	-	-	289	578	578	578	1,155	1,155	1,155	1,155	1,155	1,155	1,700	1,700	1,700	1,700
Additional Staffing Costs - Support Services	-	-	183	734	734	734	734	734	734	734	734	734	734	734	734	734	734	734	734	734
Total	**30,486**	**28,943**	**27,852**	**27,153**	**27,153**	**27,153**	**27,442**	**27,731**	**27,731**	**27,731**	**28,308**	**28,308**	**28,308**	**28,308**	**28,308**	**28,308**	**28,853**	**28,853**	**28,853**	**28,853**
Expenditure - Non Pay																				
Clinical supplies	1,306	1,297	1,298	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295	1,295
Drugs	808	803	803	801	801	801	801	801	801	801	801	801	801	801	801	801	801	801	801	801
Pathology & Blood	2,058	2,045	2,045	2,041	2,040	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041	2,041
Other	915	915	973	1,186	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298	1,298
Changes to Non Pay due to Activity	-	-	-	-	-	-	85	210	250	250	290	331	373	414	456	499	542	585	629	673
Total	**5,087**	**5,060**	**5,119**	**5,323**	**5,434**	**5,436**	**5,521**	**5,646**	**5,686**	**5,686**	**5,726**	**5,767**	**5,809**	**5,850**	**5,892**	**5,935**	**5,978**	**6,021**	**6,065**	**6,109**
Total Direct Costs	**35,573**	**34,002**	**32,970**	**32,476**	**32,588**	**32,589**	**32,963**	**33,377**	**33,417**	**33,417**	**34,034**	**34,075**	**34,117**	**34,158**	**34,200**	**34,243**	**34,831**	**34,874**	**34,918**	**34,962**
FM costs	417	471	471	471	471	471	471	471	471	471	471	471	471	471	471	471	471	471	471	471

Additional Rental contribution from UCC	-	-	(13)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)
Support Service Costs	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647	3,647
Overheads	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619	6,619
Transformation Funding assumed	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Reduction to costs in the Emergency Pathway	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Depreciation	(177)	(177)	25	637	637	637	637	637	637	637	637	637	637	637	637	637	637	637	637
Rate of Return	(45)	334	686	720	698	670	642	613	585	557	529	500	472	444	416	387	359	331	302	274
Total Costs (Baseline)	**46,034**	**44,896**	**44,405**	**44,521**	**44,610**	**44,583**	**44,929**	**45,315**	**45,327**	**45,298**	**45,887**	**45,900**	**45,914**	**45,926**	**45,940**	**45,955**	**46,515**	**46,529**	**46,545**	**46,561**
Net (deficit)	**(10,816)**	**(10,825)**	**(10,310)**	**(10,768)**	**(10,905)**	**(10,812)**	**(11,018)**	**(11,083)**	**(10,771)**	**(10,414)**	**(10,671)**	**(10,349)**	**(10,023)**	**(9,693)**	**(9,360)**	**(9,024)**	**(9,229)**	**(8,885)**	**(8,538)**	**(8,187)**

5.5. Workforce Plan

Key to delivery within financial balance is the development of an appropriate workforce to support activity levels within the new Emergency Floor. The workforce plan has been developed in line with assumptions made in the OBC and fully aligns with the capacity and financial models presented in this FBC. The detailed workforce plan is attached as Appendix 5C. This plan describes the overarching process for determining the proposed revenue cost reduction and includes details of both financial and non financial benefits arising from the development of the emergency floor. The plan also includes potential risks and actions to mitigate these.

The Trust has an overarching five year workforce plan for 2014-19. The plan has six core themes:

- Safe Staffing Models
- Reduction in dependency on non contracted workforce
- Implications of seven day service provision
- Changing models of urgent and emergency care pathways
- Movement of core secondary care activity from the acute setting
- Increased specialised services within the acute setting.

The first four themes are particularly relevant to the Emergency Floor plan.

- **Safe Staffing Models**: in determining workforce changes that could potentially arise from improvements in productivity, care has been taken to ensure safe staffing principles underpin the changes i.e. ensuring minimum shift coverage/ adopting the use of acuity tools.
- **Reduction in dependency on non contracted workforce**: in common with many emergency departments, the national shortage of both suitably qualified medical and nursing staff has led to increased expenditure on the non contracted workforce. Significant improvements have been made in recent months and further improvement is expected as outlined in this case.
- **Seven day services**: the emergency care pathway is covered by the Keogh Seven Day Service standards which established minimum standards of intervention times for core staff groups to ensure appropriate and timely decision making. UHL is currently progressing towards these standards and the workforce plan for the Emergency Floor is predicated on assumed flow from the emergency department to base wards.
- **Changing models of urgent and emergency care pathways**: The workforce model is predicated on best practice identified in both the ECIST model and through advice and guidance provided by Dr Ian Sturgess. These models of care are referenced in the detailed workforce plan.

A number of assumptions have been built into the workforce planning processes for the Full Business Case for the Emergency Floor. Overall the aim of the workforce plan is to:

- Ensure the appropriate supply and skill mix to consistently deliver the 95% ED target, and a number of individual key performance indicators within different

components of the Emergency Floor e.g. 95% of patients to be discharged from Minors within 2 hours

- Ensure the right staffing levels are available in all components of the floor to ensure the correct 'gearing' to achieve the identified standards and manage surges in activity
- To ensure an efficient model of workforce provided at less cost per activity than the current model
- To ensure the workforce model provides an education, training and career framework model that supports a sustainable future supply of workforce, taking into consideration the fragility of the ED workforce and the need to recruit and retain in the future.

The assumptions in the planning process are:

- All steps in the process need to add value to ensuring the correct dispersal of patients
- Safe staffing levels will be driven by the changes in physical location including increased bays and bed capacity in addition to the impact of increased productivity
- 80% of patients entering as ambulant patients should experience no wait and no delay
- Minors should aim to run to 2 hours to dispersal not the current 4 hour position
- It will be assumed that the IT system will link to the GP system and the Emergency Department will be an early adopter of the Trust's Electronic Patient Record
- An appropriate imaging facility will be available in MIAMI to ensure rapid assessment of patients
- TAKT timings should underpin and drive calculations of capacity requirements together with modelling of clinical activity which has been appropriately profiled
- Specialties need to be aligned to ensure rapid turnaround e.g. appropriate in reach models and preparation to receive patients. ED must not be regarded as a holding area
- A hot lab facility will be available which would allow blood test results to be generated in 40 minutes. This will impact on HCA time as results will be expected to be right first time
- Wherever possible knowledge of patients should be transmitted to ED in advance of arrival
- Bed Bureau patients will be diverted directly to the GP Assessment Area rather than through the ED
- The department will enhance its reputation as a learning and training environment by creating clear career pathways in order to mitigate against retention issues and escalating non contracted pay issues

Taking into consideration these assumptions, work has taken place to model predicted activity levels within each part of the ED function, calculate processing times and use these as the basis for calculating numbers of staff required. This modelling is to be

based on detailed operating procedures in order to ensure new models of care drive the workforce model rather than current patterns of workforce.

It should be recognised that professional judgement will then need to be applied to ensure risks to ongoing supply are managed. For example the medical staffing model requires 5-10 years of education to deliver the required skilled consultant workforce and reducing levels of junior medical staff to reflect reductions in activity in years one to five could stifle the workforce supply for subsequent years.

It is recognised that the creation of a designated Imaging suite within the Emergency Floor will increase the workforce costs for that area; however it is expected that the detailed workforce analysis will identify an offset in this cost by increased productivity for the ED Consultants, who will no longer need to verify the X-rays the following working day.

5.5.1 Uplift in Workforce for Imaging

Reporting Radiographers

Imaging is proposing an uplift in reporting radiographers to the Emergency radiology team, in order to provide a hot reporting service to ED.

This model of working forms part of the recommendation of the Trust's critical safety actions on results. Musculoskeletal (MSK) X-rays are reported immediately following the attendance in the X-ray room giving the ED clinician immediate access to a formal report. Currently the reports are reviewed by a radiologist within 48 hours, and then the results are checked by an ED Doctor; consequently a percentage of patients are recalled with missed fractures. Removing the need for this process does provide some cost saving in ED, and improved patient safety and experience.

This is a quality initiative and forms part of the Imaging team’s workforce strategy. Strengthening the Reporting radiographer team will provide cost effective and high quality imaging reporting services.

Radiographers

Two X-ray rooms and 2 CT rooms are being transferred from their current location and will be staffed by their current complement of radiographers. However 2 additional X-ray rooms are included in the new Emergency Floor which cannot be covered from within the existing workforce. It is proposed that the additional rooms are staffed at a mixed skill level from 4 - 6 to match the current skill mix within Imaging. This has been benchmarked as a low banded mix and at low levels compared to other similar hospitals.

The addition of these two rooms will prevent the build up of queues and improve patient flow through ED.

Radiography Assistants

Support staff to be working in a pool across all areas.

Receptionists

The waiting room is situated out of sight of the Imaging staff, therefore an increased number of reception staff is required to ensure patients are safe and a presence is felt in the department. This was agreed as part of the negotiations around the location of

the waiting room at a distance from the Imaging rooms which was felt presented a risk which needed to be mitigated by the addition of extra reception cover.

5.5.2 Uplift in Workforce for Pathology

The Emergency Floor laboratory will provide an improved turnaround for all routine bloods from the emergency floor. This will improve patient safety and clinical outcomes, as well as reducing risk and waiting times. ED staff will also be able to work more efficiently as the requirement for near patient testing will be removed, and so staff will be able to spend their time treating patients rather than testing blood samples themselves.

Due to the size of the Hot Lab, this facility is only able to provide a service for the Emergency Floor and therefore the existing laboratory will have to remain open 24/7 to service the rest of the hospital. The Emergency Floor facility will be staffed as a subsidiary hot lab and additional staffing has been requested to ensure the 24 hours a day, 7 days a week service requirement is achieved.

5.6. Impact on Trust Balance Sheet

The table below sets out the impact on the Trust's balance sheet. Further details to support these figures are within Appendix 5A.

Table 5.7 Impact on Trust's Balance Sheet

	2013 /14 £	2014 /15 £	2015 /16 £	2016 /17 £	2017 /18 £
Assets Under Construction	568,764	6,368,024	17,698,095	18,341,114	353,031
Impairments on new building coming into use (DV likely revaluation)				-15,718,000	
Impairment on partial demolition of Victoria based m^2		-2,424,261			
Depreciation				-201,870	-807,481
Change to Fixed Assets	568,764	3,943,762	17,698,095	2,421,244	-454,450

As can be seen, the demolition of part of the existing Victoria Building will lead to an impairment in the first instance and this has been based on the square meterage demolished as a percentage of the total building area.

The new Emergency Floor project is expected to be available in June 2017. Prior to this it is treated as an asset under construction.

Once fully operational, we have assumed that as a result of the District Valuer valuation there will be an impairment of 38%.

The value of these impairments is shown below; further details to support these figures are within Appendix 5A.

Table 5.8 Value of Impairments

Impairments	£K
Demolitions	2,424
New asset coming into use	15,718
Total	**18,142**

5.7. Capital Charges

Below we set out the calculations which underpin the capital charge calculations which are shown within the I&E at table 5.6. Further details to support these figures are within Appendix 5A.

Table 5.9 Capital Charge Summary

	2014 /15 £	2015 /16 £	2016 /17 £	2017 /18 £	2018/19 £	2019/20 £
New depreciation	0	0	201,870	807,481	807,481	807,481
Reduction in depreciation re demolition	-177,031	-177,031	-177,031	-170,071	-170,071	-170,071
Change in depreciation	-177,031	-177,031	24,839	637,410	637,410	637,410
Reduction in RoR re demoltion	-114,051	-114,051	-114,051	-114,051	-114,051	-114,051
RoR on new build	69,016	447,748	799,837	834,256	812,172	783,910
Change in rate of return	-45,035	333,698	685,786	720,205	698,121	669,859

5.8. Sensitivity

A key sensitivity for the Trust is the activity levels. The Trust has set out in Section 5.4 the impact on the I&E position of activity based on the Better Care Together scenario. This assumes a 7.3% reduction in activity in 2015/16, and this has to be contrasted with an underlying increase in ED activity of circa 8%. An 8% increase in activity approximately equates to an increase in income of £3 million. The Trust has assumed that the cost of delivering the additional activity would be circa £1.65 million. Any level of activity higher than that assumed in the business case therefore will improve the Trust's income and expenditure position.

5.9. Affordability

In developing the FBC efficiencies have been identified which demonstrates the case is affordable to the Trust. The efficiencies, outlined in table 5.4, have been developed through detailed activity, capacity and workforce planning.

5.10. Impact of a loan option

Below we have modelled the impact of a loan option for funding. In accordance with the OBC this case assumes that PDC financing will be available as the most affordable mechanism to support this development. However, in order to demonstrate the impact of financing through a loan the impact of this has been modelled below. Key assumptions are:

- The first drawdown is in mid 2015/16 and thereafter mid year
- Interest rates are 3.27% and are based on the Government Works Loan rates for equal annual payments
- The loan will be for a 25 year period from the first drawdown

Clearly under a loan option the Trust will no longer incur the rate of return charge of 3.5% pa on PDC and this has been reflected in the table below.

As can be seen the impact of a loan is to add additional costs to the I&E of c£2.1M pa. The cash impact of a loan option has also been modelled and this is set out below. Further details to support these figures are within Appendix 5A.

Table 5.10 Impact of a Loan

	2014 /15 £	2015 /16 £	2016 /17 £	2017 /18 £	2018/19 £	2019/20 £
Reduction in PDC	-69,016	-447,748	-799,837	-834,256	-812,172	-783,910

Loan repayment		492,698	1,352,218	1,726,100	1,733,161	1,733,161
Loan Interest		694,602	1,350,758	1,300,087	1,243,413	1,186,738
Additional Cost	**-69,016**	**739,551**	**1,903,139**	**2,191,932**	**2,164,402**	**2,135,989**

Table 5.11 Cash Impact of a Loan

	2014 /15 £	2015 /16 £	2016 /17 £	2017 /18 £	2018/19 £	2019/20 £
Loan repayment			492,698	1,352,218	1,726,100	1,733,161
Loan Interest			694,602	1,350,758	1,300,087	1,243,413
Additional Cash Impact	**0**	**0**	**1,187,300**	**2,702,976**	**3,026,187**	**2,976,574**

5.11. VAT Recovery

The VAT assessment is normally calculated on a percentage basis. In order to be aggressive on VAT recovery, and to get certainty, the Trust has engaged a recognised VAT Consultant from the Heart of England NHS Trust who will review the project in order to provide VAT certainty and target the upper bounds of VAT recovery.

5.12. Long Term Financial Model

The Trust submitted an LTFM in June 2014 in support of the IBP. The LTFM is continuously being refreshed for various purposes including supporting business case submissions and their approval by the appropriate authorities. The impact of this FBC on the LTFM can be found at Appendix 5D.

6 | The Management Case

6.1 Introduction

The Management Case provides a summary of the arrangements which have been put into place for the successful delivery of the proposed Emergency Floor development, the associated other service relocations required as a result of the decanting moves, service operational changes, and to secure the benefits sought through the investment.

PRINCE2 methodology is being applied to this project.

6.2 Project Governance Arrangements

Project Governance arrangements have been established to reflect national guidance[24] and the Trust's own Capital Governance Framework, as shown in the diagram below:

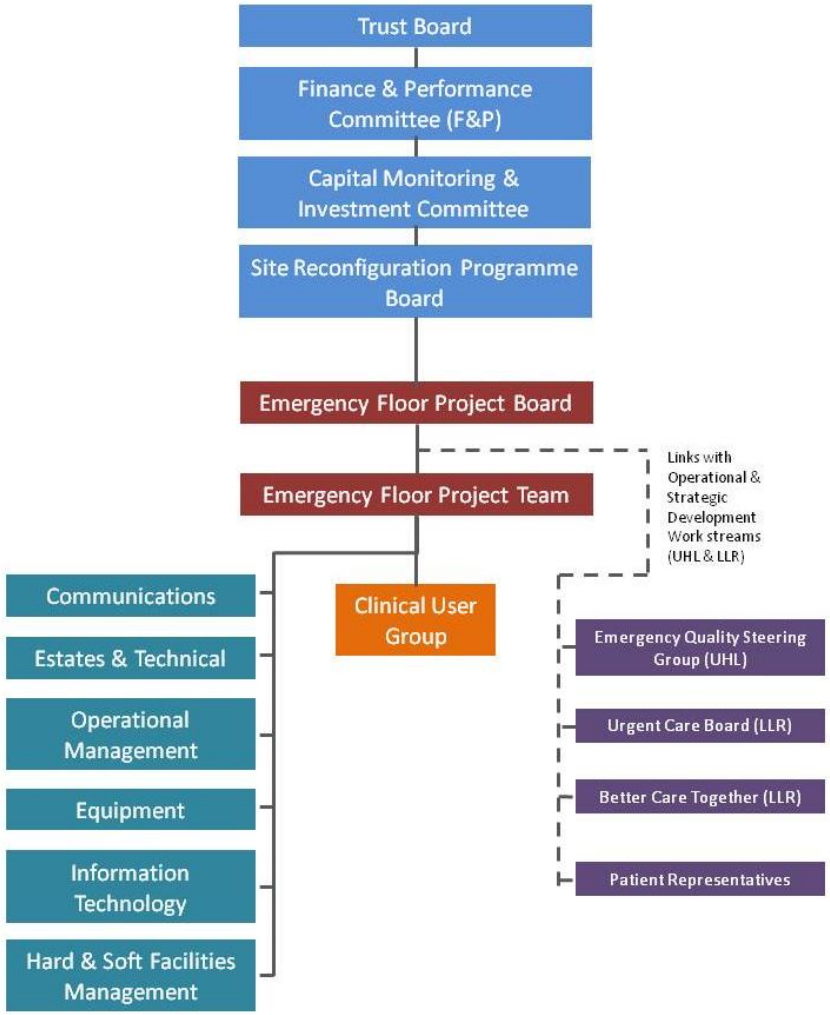


Figure 6.A UHL Capital Governance Framework

[24] Capital Investment Manual 'Managing Capital Projects' (Department of Health); PRINCE2 (Office of Government Commerce); Managing Successful Programmes (Office of Government Commerce/ Efficiency & Reform Group)

6.3 Outline Project Roles & Responsibilities

Key Project delivery roles are described below:

- **Senior Responsible Owner (SRO):** This role is being performed by John Adler (Chief Executive), with responsibility to the Executive Trust Board for delivery of the project to meet their terms of reference. Kevin Harris (Medical Director) chairs the Project Board.
- **Senior User:** This role is being performed by Catherine Free (Clinical Director for the Emergency & Specialist Medicine CMG), with responsibility for ensuring that the project maintains alignment with the service and business targets described in the Business Case and working within the terms of reference set by the Project Board.
- **Project Director:** This role is being performed by Nicky Topham (Project Director) with overall responsibility for delivery of the project in accordance with the project brief.
- **Development Project Manager:** This role is being performed by Phil Tranter (Project Manager for Rider Levett Bucknall), who will have day to day responsibility for administration of the development of the project (within the delegated role permitted by Project Board).
- **Service Project Managers:** Senior managers from the ED and associated departments that are proposed to make up the Emergency Floor solution will undertake this role, having day to day responsibility for providing advice on the service brief to the development team and for planning and delivery of service and workforce change under the direction of the Senior User.

Regular Progress Reports are submitted to the Capital Planning Group, Executive Strategy Board and Trust Board for onward reporting and management within the established Trust management structure.

6.3.1 Core Groups & Responsibilities

A Project Execution Plan (PEP, included at Appendix 6A) has been prepared to provide detailed information on proposed project management arrangements, including:

- Aims and objectives
- Benefits and constraints
- Organisation
- Roles and responsibilities
- Detailed programme for stage activities
- Risk management arrangements
- Statutory Approvals and Quality Standards
- Project Communications

The roles and responsibilities for the main project groups are summarised as follows:

Executive Strategy Board (ESB)

This group is a designated committee appointed by the Trust Board, with responsibilities which in summary, include:

- Advising the Trust Board on formulating strategy for the organisation.
- Ensuring accountability by holding each other to account for the delivery of the strategy and through seeking assurance that all systems of control are robust and reliable.
- Leading the Trust executively, in accordance with the Trust's shared values, to deliver the Trust's vision and, in doing so, help shape a positive culture for the organisation.

Emergency Floor Project Board

The membership of the Project Board is:

Table 6.1 Emergency Floor Project Board Membership

Member	Title
Dr Kevin Harris	Chair/ Medical Director
Richard Kinnersley	Major Capital Projects Technical Director, UHL
Nicky Topham	Project Director/ Programme Director of Reconfiguration, UHL
Paul Traynor	Director of Finance
Phil Walmsley	Head of Operations
Dr. Catherine Free/ Jane Edyvean	Senior User/ Emergency & Specialist Medicine CMG Representative
Dr. Andrew Furlong	Senior User/ Deputy Medical Director
Dr. David Yoemanson	Senior User/ Woman's & Children's Divisional Representative
John Clarke	Chief Information Officer
Ian Crowe	Non Executive Director
Michael Pepperman	Healthwatch representative
Tiff Jones	Head of Communications

Key roles and responsibilities include:

- Responsibility for delivering the project within the parameters set within the business case
- Providing high level direction on stakeholder involvement and monitoring project level management of stakeholders
- Providing the strategic direction for the project
- Ensure continuing commitment of stakeholder support
- Key stage decisions

- Progress monitoring

Monthly progress reports, including projections of forthcoming key activities and decisions, will be submitted to the Project Board by the Project Director. The standing agenda will be as follows:

- Apologies
- Minutes of Previous Meeting
- Matters Arising
- Highlight Progress Report
- Work-stream updates:
  - Operational issues – including workforce and clinical commissioning
  - Procurement
  - Finance
  - IM&T
  - Design & Construction
  - Stakeholders and Communications
- Any other business
- Date of Next Meeting

Emergency Floor Project Team Meeting

The membership of the Emergency Floor Project Team Meeting is the work-stream leads:

Table 6.2 Emergency Floor Project Team Membership

Member	Title	Role (work-stream lead)
Nicky Topham	Project Director, UHL	Chair
Richard Kinnersley	Major Capital Projects Technical Director, UHL	Estates & Technical
Jane Edyvean	CMG General manager	Workforce, activity & clinical commissioning
John Clarke	Chief Information Officer	IT
Richard Pitt	Head of Procurement	Equipment
Tiff Jones	Communications Manager	Communications
Louise Gallagher	Workforce manager	Workforce professional advisor
Paul Gowdridge	Head of Strategic Finance	Finance
TBC	Interserve FM	Hard & Soft FM

This fortnightly group is a designated committee appointed by the Project Board, with responsibilities which ensures:

- Operational delivery of the scheme to time, quality and budget.
- Decision on matters for escalation for ESB and Trust Board direction/ information

- Management of risks and issues and escalation of appropriate matters for executive direction/ approval
- Drawing together the outputs of the Working Groups and coordination of cross cutting issues

Working Groups

Working Groups will be convened by the leads as above to provide advice and direction to the detailed design process. Their roles can be summarised as follows:

- **Estates & Technical Group:** This group will be led by the Trust's appointed Senior Supplier and Contractor, Interserve Construction Ltd, and will be responsible for:
  - Managing design progress and coordination issues
  - Identifying key matters for Trust assistance/ decision making
  - Identifying design risks and issues for management and if appropriate escalation to the project team
  - Service Development: Representing clinical services, responsibilities will include:
    - Provide comment to the Project Manager on Reviewable Design Information
    - Liaise with Infection Control to gain advice on final product/ detail selection issues
    - Refinement of Operational Policy(s)
    - Support the work of the Equipping process in preparation of key stage documents

- **Operational management**: This group will be responsible for the clinical operational aspects and deliver y of the scheme. This will include:
  - Agreement of activity
  - Creation of the workforce plan and delivery of the models to achieve the agreed efficiencies
  - Clinical commissioning e.g. training, orientation

- **Equipping Group:** This group will be responsible for confirmation and procurement of equipment required for the operational needs of the Emergency Floor development. This will include:
  - Producing equipment schedules
  - Planning the procuring of equipment in accordance with the Trusts SFIs and SOs and to ensure compliance with BREEAM obligations
  - Planning the commissioning of equipment
  - Understanding the transfer requirements of existing equipment/ furniture (as appropriate)
- **Hard & Soft Facilities Management:** This group will represent the needs of hard and soft FM for the development of the Emergency Floor, and will provide the following support:

- Providing comments to the Project Manager on reviewable design Information
- Advising on FM related fittings, fixtures and equipping selection as part of the detailed design process
- Updating whole hospital policies and service agreements to reflect the departmental operation of the proposed Emergency Floor
- Advising on risks or issues which may threaten the success of the scheme
- Managing delivery of client related BREEAM obligations

- **Information Management & Technology:** This group will be responsible for ensuring that voice and data requirements are delivered for the scheme, along with advice on equipment which is linked with communications (e.g. Electronic Paper Records (EPR) System, CCTV, entry systems, BMS etc). This will cover the following:
  - Addressing any queries from the Design Team in relation to the design of cabling and associated works
  - Reviewing any design information in relation to ICT
  - Planning the transfer and commissioning of voice and data provision from the existing operating locations to the new development

- **Communications:** This group is responsible for the delivery of the communications strategy. This will include:
  - Proactive communications for internal & external audiences on a regular basis (see Section 6.5)

Emergency Floor Clinical User Group

The membership of the Clinical User Group is:

Table 6.3 Emergency Floor Project Steering Group Membership

Member	Title
Nicky Topham	Project Director
Steve Kennedy	Design Manager – Interserve Construction
Roger Bancroft	Construction Project Manager – Interserve Construction
Aaron Vogel	Emergency Planning Officer
Andrew Rickett	Clinical Lead Imaging
Andy Coser	ED Matron
Angus McGregor	Clinical Lead Pathology
Anna Duke	Paediatric ED Matron
Anne Freestone	Pathology
Ben Teasdale	Clinical Lead ED
Catherine Free	Emergency Medicine Medical Lead
Cathy Lea	Imaging Service Manager

Member	Title
Chris Wighton	Clinical Lead SSPAU
Claire Ellwood	Clinical Lead Pharmacy
Colin Ross	Imaging
David Jenkins	Infection Prevention
Emily Laithwaite	Clinical Lead EFU / AFU
Geraldine Burdett	Clinical Lead Mental Health
Jane Edyvean	Emergency Medicine CMG Manager
Jay Banerjee	ED Consultant
Joyce Burns	Clinical Lead Ophthalmology
Julie Burdett	RAU / ACB / GP Initial Assessment
Kerry Morgan	ED Deputy Head of Nursing
Kim Wilding	Clinical Lead UCC
Lee Brentnall	EMAS Representative
Lee Walker	Clinical Lead Medical Assessment
Lisa Lane	ED Deputy Head of Nursing
Liz Collins	Infection Prevention
Marianne Elloy	Clinical Lead ENT
Mark Williams	Clinical Lead EDU
Mike Dunn	Radiation Protection Advisor
Paula Knowles	EDU Matron
Rachel Williams	ED Senior Service Manager
Sam Jones	Clinical Lead Paeds ED
Simon Conroy	EFU/ AFU
Tee Taylor	SSPAU Matron
Vicki Enright	ED and Medical Assessment Operational Manager

This group will be chaired by the Project Director. Key roles and responsibilities will include:

- Day to day responsibility for the clinical delivery of the project to meet the parameters described within the business case
- Provision of appropriate reports on status to the Project Director
- Providing working groups with detailed briefs
- Ensure continuing commitment of stakeholders, both internal and external

The group will meet monthly or more frequently as required in accordance with the phase of the project.

6.3.2 Project Plan

The Project Programme is intended to deliver the project by summer 2017, though this timeline is predicated on meeting key submission and approval dates to both the Trust Board and NTDA.

The construction programme (Appendix 6B) identifies the anticipated construction timeline for the Phase 1 new build, and a provisional Timeline for the Phase 2 refurbishment works based on the drawn solution. The Phase 2 programme will be amended to reflect the intended design changes arising from the Trusts review of the Operational Policies and Schedule of Accommodation which will result in the issue of a new Briefing document. This change will be covered by a Compensation Event to amend the Works Information and adjust the Total of the Prices and Project Timeline.

Table 6.4 Project Milestones

Milestone	Date
Outline Business Case presented to Trust Board Development Session	21st Nov 2013
Outline Business Case presented for Trust Board approval	28th Nov 2013
Outline Business Case sent to the NTDA	Dec 2013
Outline Business Case presented to CCGs & UCB	Dec 2013
Commence Detailed Design & Full Business Case	Feb 2014
Submission of Planning Application	2nd Jun 2014
Trust commit to place order for early procurement items	2nd Jun 2014
Trust Board approval of Developed Outline Business Case	28th August 2014
Trust commit to place order for early works (isolation, diversion)	5th Sept 2014
LCC Planning Approval	24th Sept 2014
Trust commit to place order for demolition works	25th Sept 2014
Commence isolation, diversion, demolition works	December 2014
NTDA approval of Developed Outline Business Case	6th Jan 2015
Trust Board approval of Full Business Case	8th Jan 2015
NTDA submission of the Full Business Case	9th Jan 2015
NTDA approval of the Full Business Case	19th March 2015
Isolation, Diversion, Demolition complete	May 2015
Commence construction (Phase 1 – ED)	May 2015
Complete construction (Phase 1 – ED)	Winter 2016
Commence construction (Phase 2 – Medical Assessment & Frailty Units)	Winter 2016
Complete construction (Phase 2 – Medical Assessment & Frailty Units)	Summer 2017

6.4 Use of Special Advisors

Special advisers have been used in a timely and cost-effective manner in accordance with the Treasury Guidance.

Table 6.5 External Advisors

Emergency Floor Development		
1	Interserve Construction Ltd	Building/ Construction Supervisors
2	Interserve Engineering Services	MEP Detailed Design & Installation
3	Rider Levett Bucknall	Project Management & Cost Advisors
4	Capita	Architects
5	Capita	Cost Consultants
6	Capita	Business case / Finance analysis
7	Capita	Structural Engineers
8	Capita	Mechanical and Electrical Engineers
9	Capita	CDM

6.5 Stakeholder Engagement

A Communications Strategy (Appendix 6C) has been developed in consultation with the Trust's Communications and Marketing Team; this identifies key stakeholder groups and key messages that need to be shared at key milestones in the project. This is an extremely important plan for the Trust since the Emergency Floor project represents the first large capital project being undertaken as part of a wider Trust reconfiguration plan.

Stakeholders have been identified as follows:

Table 6.6 Key Project Stakeholders

NHS Staff	Patients
UHL – all staff	Patients and Visitors
LRI – all staff, especially those working in ED, Medical Assessment and Frailty Units	Patient Representatives – Healthwatch
GPs and other referrers	UHL Patient Advisors
CCGs	UHL Volunteers
Service Providers – Interserve FM, staff from George Elliot Hospital Trust	
External Stakeholders	**General**
Leicester City Council	People living in Leicester and the surrounding areas
League of Nurses	The general public

Heritage Groups	The media – print, TV and radio
MPs & Ward Councillors	
NHS Trust Development Authority (NTDA)	
Local Area Team (LAT)	
Age Concern & Age UK	
University of Leicester	
Conservation Area Advisory Panel	
Professional Groups	
Royal Colleges	

Methods of communicating information about the Project to various Stakeholders are detailed below:

6.5.1 Internal

- **Face to face briefings:** These should be used as the primary source of communication with staff
- **INsite pages:** A section on the Emergency Floor reconfiguration project can be included on the staff intranet pages
- **Display boards/ Hoardings around building work**
- **Hospital Hopper:** Information can be displayed aboard and on the exterior of the Hospital Hopper buses, which travel between the three UHL hospital sites.
- **Factsheet style newsletter**
- **Blueprint & Chief Executive's Briefings:** Utilise Blueprint reconfiguration newsletter for staff (bi-monthly) to update staff on progress.

6.5.2 External

- **Social media:** Utilising the Trust's Twitter and Facebook accounts
- **Website:** A section on the Emergency Floor reconfiguration project can be included on the UHL website, with a link from the homepage
- **Local media**
- **Leicester Mercury Patient Panel:** Panel made up of members of the public who provide comment on local issues
- **Annual public meeting (September):** Use this as an opportunity to share what has been accomplished and what is planned next
- **Patient information leaflet**
- **University Hospitals of Leicester Membership:** A group of over 14,000 local people who have expressed an interest in what we do. Members are representative of Leicester's population in terms of sex, ethnicity and age.

6.6 Outline Arrangements for Change & Contract Management

The Change Control procedures will be undertaken in accordance with the flow charts identified within the NEC3 contract framework.

Project specific versions of these will be prepared identifying the basic process in relation to:

- Issue of Project Manager's Instruction
- Contractor confirms price and programme implications within 3 weeks
- Project Manager raises Compensation Event within 2 weeks if in agreement
- Client Accepts Compensation Event and signs accordingly
- Contractor updates Programme

Change management associated with the project will be managed through the Project Board and executive forums that preside over it, under the chairmanship of the Senior Responsible Owner (SRO) and Trust Board respectively. Day to day change management issues will be discussed at the Emergency Floor Project Team meetings and any resultant contract and/ or cost changes will need to be approved by the Project Board.

6.7 Outline Arrangements for Benefits Realisation

The delivery of benefits will be managed through the Emergency Floor Project Board. A copy of the benefits realisation plan can be seen in Section 2.17; this sets out who is responsible for the delivery of specific benefits, when they will be delivered, and how achievement of them will be measured. The key opportunity is presented by the new design for facilities, which will ensure sufficient capacity to meet demand, efficiencies in service delivery, compliance to standards and minimised disruption to overall Trust operations.

Key benefits of the project are:

- To implement a design solution that provides a safe emergency care service that ensures capacity and known flexibility for current and known future demands of patients requiring emergency care
- Improve patient pathway management reducing the clinical risk and discomfort through the emergency care pathway
- Support and consolidate the provision of an Emergency Floor concept at LRI
- Ensures that the service model of care is delivered in line with National, Trust and local health economy KPI's
- Patient safety is enhanced, and clinical risk is reduced
- Where possible ensures that the service is developed in line with NHS Guidance in terms of HBN, HTM, national and Trust policy and local health economy policy in terms of capacity provision

- Quality of care is enhanced, in terms of the model of care, and seamless pathways of care and patient flows
- The built environment enhances clinical practice that support clinical effectiveness, improved patient outcomes and patient safety
- Provides enhanced departmental relationships and clinical adjacencies that support clinical effectiveness and improved patient outcomes
- Ensures facilities are future proofed and adaptable to the changing needs of the health economy
- Improved Privacy and dignity provisions for all patients
- Consolidates existing services & provides clinical expertise whilst realising the Emergency Floor concept
- Improved patient access through a single front door process
- Enhances patient, visitor and staff safety through the built environment
- The design solution minimises the impact of the construction process on the site and therefore delivery of the Trust core services
- Option enables future proofing of the physical ED environment aligned to DCP future expansion needs
- The enabling moves will facilitate the Emergency Floor programme whilst minimising delay to delivery
- Reduces complexity and sequence dependency of enabling moves
- Maintains blue light access throughout whole build process

6.8 Outline Arrangements for Risk Management

All projects are subject to risk and uncertainty. Successful project management should ensure that major foreseeable risks are identified, their effects considered and actions taken to remove, or mitigate the risks concerned.

Risks will be classified as:

- Client – these will be the responsibility of the Project Board to manage and monitor
- Contractor – a project specific risk register will be set up for the Project. These will be the responsibility of the Contractor to monitor and will form part of the GMP

The qualification of the costs of identified risks will enable the calculation of a realistic client contingency.

A pro-active risk management regime will be employed throughout the project. It is essential on any project (in particular one of this size and complexity) that the risk management process involves all key members of the project team including:

- Trust Estates
- Trust FM
- Project Consultant Team
- Contractor

- Designers

6.8.1 Risk Management Policy

The risk management system is described in the Trust's Risk Management Policy which is accessible to all staff via the Trust Intranet. It is based on an iterative process of:

- Identifying and prioritising the risks to the achievement of the organisation's policies, aims and objectives
- Evaluating the likelihood of those risks being realised and the impact should they be realised
- Managing the risks efficiently, effectively and economically

This is achieved through a sound organisational framework, underpinned by a robust policy framework, which promotes early identification of risk, the co-ordination of risk management activity, the provision of a safe environment for staff and patients, and the effective use of financial resources.

The Trust Risk Register details, in order of relative importance, all the significant risks facing the Trust which are most likely to affect (positively or otherwise) achievement of the Trust's objectives.

All new Trust employees attend the corporate induction course, which includes elements of risk management, before they commence their duties in the workplace. This corporate induction is followed by a local induction, delivered by the service line manager, during which time staff receive information on risks specific to that service.

Risks are identified through feedback from many sources such as proactive risk assessments, adverse incident reporting and trends, clinical benchmarking and audit data, complaints, legal claims, patient and public feedback, stakeholder/partnership feedback and internal/external assurance assessments. Appendix 6D provides an overview of the robust system of risk management across the Trust.

6.8.2 Assurance Framework

The Trust's Assurance Framework provides it with a simple but comprehensive method for the effective and focused management of the principal risks to meeting the Trust's corporate objectives. In this way it provides a structure and describes the controls and assurance mechanisms in place to manage the identified risks. This simplifies Board reporting and the prioritisation of action plans, which, in turn, allows for more effective performance management.

The key elements of the Assurance Framework are:

- Establishment of the Trust's principal objectives (strategic & directorate)
- Identification of the principal risks that might threaten the achievement of these objectives
- Identification and evaluation of the key controls intended to manage these principal risks

- Setting out of the arrangements for obtaining assurance on the effectiveness of the key controls across all areas of principal risk
- Evaluation of the assurance across all areas of principal risk
- Identification of the positive assurances and areas where there are gaps in controls and or assurances
- Putting in place of plans to take corrective action where gaps have been identified in relation to principal risks
- Maintenance of dynamic risk management arrangements including, crucially, a well-informed risk register

Therefore, the Assurance Framework provides a simple framework for reporting key information to Boards. It identifies which of the organisation's objectives are at risk because of inadequacies in the operation of controls or where the organisation has insufficient assurance about them. At the same time it provides structured assurances about where risks are being managed effectively and objectives are being delivered.

The primary focus is confidence that effective processes are in place to deliver the strategic objectives of the Trust. This allows Boards to determine where to make efficient use of their resources and address the issues identified in order to improve the quality and safety of care.

Where any significant gaps in assurance are identified they are transferred to the risk register and an action plan is developed.

6.8.3 Project Risk Register

The current risk register has been developed through a workshop environment. For each identified risk the following are noted:

- Reference
- Category
- Risk and associated likely impact
- Probability and impact factors and associated overall risk rating
- Mitigation measures
- Cost and time impacts
- Risk owner and / or manager
- Action Date

The current risk register can be found at Appendix 2T– this is a working document and will be developed throughout the duration of the project. The register will be reviewed regularly focussing on the high impact risks and those with pending Action Dates.

Over time the allocation of the individual risks (Trust or PSCP) will also be reviewed to ensure risks are placed with the party best placed to deal with it.

6.9 Outline Arrangements for Post Project Evaluation

The end stage of the project will result in the completion, handover and commissioning of the new facility. The Emergency Floor Project Board is responsible for providing assurance that the project has been delivered in terms of product and quality in line with the business case.

The outline arrangements for post Project Evaluation (PPE) have been established in accordance with best practice. The trust will ensure that a thorough post-project evaluation is undertaken at key stages in the process to ensure that positive lessons can be learnt from the project. These will be of benefit to:

- The Trust – in using this knowledge for future capital schemes
- Other key local stakeholders – to inform their approaches to future projects
- The NHS more widely – to test whether the policies and procedures used in this procurement have been used effectively
- Contractors – to understand the healthcare environment better

The evaluation will examine the following elements, where applicable at each stage:

- The effectiveness of the project management of the scheme – viewed internally and externally
- The quality of the documentation prepared by the Trust for the contractors and suppliers
- Communications and involvement during procurement
- The effectiveness of advisers utilised on the scheme
- The efficacy of NHS guidance in delivery the scheme
- Perceptions of advice, guidance and support from the strategic health authority and NHS Estates in progressing the scheme

Formal post project evaluation reports will be compiled by project staff, and reported to the Board to ensure compliance to stated objectives.

6.9.1 Post Implementation Review (PIR)

These reviews ascertain whether the anticipated benefits have been delivered and are timed to take place immediately after the new emergency care unit opens and then 2 years later to consider the benefits planned.

6.10 Gateway Review Arrangements

Gateway reviews provide a valuable perspective on the issues facing the internal project team, and an external challenge to the robustness of plans and processes. The Gateway process provides support to SROs by helping them to ensure the following:

- The best available skills and experience are deployed on the programme or project

- All the stakeholders covered by the programme or project fully understand the current status and the issues involved
- The programme or project can progress more confidently to the next stage of development, implementation or realisation
- Achievement of more realistic time and cost targets for the programme or project

The Gateway Project Review Process looks at a project or programme at six key stages in the life of the project and considers the readiness to progress to the next phase.

The six stages or Gates are:

- Gate 0 - Strategic Assessment
- Gate 1 - Business Justification
- Gate 2 - Delivery Strategy
- Gate 3 - Investment Decision
- Gate 4 - Readiness For Service
- Gate 5 - Operations Review and Benefits Evaluation

A Health Gateway Review 2: Delivery Strategy was undertaken and associated report issued to the Project SRO on the 18th June 2014 (Appendix 6E). A Delivery Confidence Assessment of AMBER was issued by the review team along with recommendations for consideration/ implementation.

The recommendations from the Gateway Review have been completed.

The next Health Gateway Review, Gateway 3 Investment Decision is recommended once GMP is received and the Full Business Case is complete and ready for Trust Board and other approvals. This will be in January 2015.

6.11 Contingency Plans

The Trust has a framework for Business/Service Continuity. In this instance, the Emergency Care Directorate ensures that the Trust's emergency care service contingency plans are in place for the event of any disruption.

The Trust's framework ensures the Trust can comply with the business continuity provisions of the Civil Contingencies Act 2004. Contingency plans have been developed to ensure the Trust can continue to deliver an acceptable level of service of its critical activities in the event of any disruption.

In the event that this project fails and the ED is not re-developed, the Trust will continue to implement and realise the benefits of its current Emergency Care action plan. The Trust will implement the Do Minimum albeit limiting in achieving capacity requirements and efficiencies, however it will enable a continuation of Emergency services within its existing facility.

Appendices

Appendices are attached as separate documents and consist of the following:

Appendix 1A	CCG Letter of Support
Appendix 2A	ECIST Review 2013
Appendix 2B	Design Operational Policy 2013
Appendix 2C	Emergency Care 4hr Trajectory 2013
Appendix 2D	LLR Winter Urgent Care Action Plan 2014/15
Appendix 2E	Trust Extreme & High Risks (15 and above)
Appendix 2F	Trust Moderate Risks (8-12)
Appendix 2G	Detailed Guiding Strategies
Appendix 2H	Trust Clinical Strategy (draft)
Appendix 2I	UHL 5 Year Estates Strategy
Appendix 2J	Clinical Justification
Appendix 2K	Model of Care
Appendix 2L	Clinical Operational Policy - ED
Appendix 2M	Clinical Operational Policy - Assessment
Appendix 2N	Clinical Operational Policy - Support
Appendix 2O	Clinical Service Dependencies
Appendix 2P	Imaging Turnaround Times Report
Appendix 2Q	Estates Annex
Appendix 2R	CQC Inspection Report 2014
Appendix 2S	DQI Report 2014
Appendix 2T	Risk Register
Appendix 3A	FB forms
Appendix 3B	Notes on FB forms
Appendix 3C	Comparison between OB forms and FB forms
Appendix 3D	GMP
Appendix 3E	1:200 First Floor New Build
Appendix 3F	1:200 First Floor Refurbishment
Appendix 3G	1:200 Ground Floor New Build
Appendix 3H	1:50 Resus
Appendix 3I	1:50 Majors

Appendix 3J	1:50 MIAMI
Appendix 3K	1:50 Streaming Zone
Appendix 3L	1:50 Adult Reception & Waiting
Appendix 3M	1:50 Paediatric ED
Appendix 3N	1:50 SSPAU
Appendix 3O	1:50 EDU
Appendix 3P	1:50 EFU & AFU
Appendix 3Q	1:50 RAU (partial)
Appendix 3R	1:50 ACB & RAU (partial)
Appendix 3S	1:50 GP Referral Unit
Appendix 3T	1:50 Diagnostic Imaging
Appendix 3U	1:50 Ground Floor
Appendix 3V	Construction Materials Palette
Appendix 3W	Roof Plan New Build
Appendix 3X	Visualisation Adult Main Entrance
Appendix 3Y	Visualisation Paediatric Main Entrance
Appendix 3Z	Schedule of Accommodation
Appendix 4A	Planning Approval & Conditions
Appendix 4B	Planning Conditions Tracker
Appendix 4C	BREEAM Interim Certificate
Appendix 4D	Equipment List (capital)
Appendix 4E	Equipment List (revenue)
Appendix 5A	Capital Costs
Appendix 5B	I&E and Workforce calculations
Appendix 5C	Workforce Plan (narrative)
Appendix 5D	Impact of this FBC on the LTFM
Appendix 6A	Project Execution Plan
Appendix 6B	Programme
Appendix 6C	Communications Strategy
Appendix 6D	Trust Risk Management Policy 2014
Appendix 6E	Gateway 2 Review – Final Report

Agenda Item: Trust Board Paper E

TRUST BOARD – 8 JANUARY 2015

Emergency Care Performance Report

DIRECTOR:	Richard Mitchell, Chief Operating Officer
AUTHOR:	Richard Mitchell
DATE:	8 January 2015
PURPOSE:	a) To update the Board on recent emergency care performance b) To update on progress against the LLR action plan
PREVIOUSLY CONSIDERED BY:	Emergency Quality Steering Group, Urgent Care Board and System Resilience Group
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☒ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☐ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Healthwatch representatives on UCB and involved in BCT workstream.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	None undertaken but will be in respect of new pathways within BCT.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☒ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED * For decision ☒ For assurance ☐ For information ☐	

♦ **We treat people how we would like to be treated** ♦ **We do what we say we are going to do** ♦ **We focus on what matters most** ♦ **We are one team and we are best when we work together** ♦ **We are passionate and creative in our work*** tick applicable box

REPORT TO:	**Trust Board**
REPORT FROM:	**Richard Mitchell, Chief Operating Officer**
REPORT SUBJECT:	**Emergency Care Performance Report**
REPORT DATE:	**8 January 2015**

Key points

- Performance in December 2014 was **82.9%** compared to **90.1%** in December 2013 and **89.1%** in November 2014.
- Emergency admissions (adult) continue to steadily rise in December; **221** compared to **216** per day in November and **215** per day the month before.
- Emergency admissions in December 2013 were 194 per day (**now 13% higher**).
- Delayed transfers of care remain at **5.7%**.

Performance overview

Performance remains very poor since the last Trust Board meeting on 22 December 2014. Attendance, admissions and acuity remain high at the LRI ED and also at the CDU at the Glenfield Hospital, which is now receiving higher medical takes than ever before. The 'typical' Christmas and New Year lull did not occur locally or nationally.

Actions since Trust Board on 22 December 2014

The UHL Chair called a short notice meeting for the three CCG Chairs, LPT Chair and other senior members of the health system following the UHL Trust Board in December because of the level of clinic risk linked to the unprecedented emergency demand, for this time of year, and to agree the actions we will take to more effectively manage this across the local health system.

Five actions came from this, with updates below:

1. The UHL Communications Team will work with CCG and Leicester Partnership Trust colleagues to write a joint message from the five Chairs urging patients to think carefully before accessing any part of the emergency care system this Christmas. Unless it really is an accident or emergency, the A&E Department at the Leicester Royal Infirmary is not a suitable destination for the patient's care - Update: complete
2. Following on from the Chief Nurse's call earlier today, we will re-look at the circa 120 patients across LPT and UHL who are delayed transfers of care. This number is too high and is one of the key reasons why emergency performance has been so poor. It is likely that this number will naturally reduce over the next couple of days because of the high discharges but it will increase over the weekend and early next week. A meeting took place on 29 December 2014 to identify the key themes to the DTOCs and to agree the actions taking place - Update: This was not discussed at the Urgent Care Board on 30 December but will be brought back to another UCB.
3. We agreed that there was an urgent requirement to spot purchase nursing home and care home beds to alleviate some of the pressure within UHL and LPT, whilst noting concerns about opening additional nursing and care home beds at short notice - Update: This was not discussed at the Urgent Care Board on 30 December but will be brought back to another UCB.
4. We noted that we do not currently have any surge capacity across LLR with all available beds in LPT and UHL full. This is a significant risk considering it is likely emergency pressures have not peaked yet and based on previous years, they will continue to rise until late March 2015. It has been requested that surge capacity plans are urgently reviewed - Update: This was not discussed at the Urgent Care Board on 30 December but will be brought back to another UCB.
5. We agreed that we need to undertake a collective risk assessment across LLR to jointly understand the nature and comparable size of the current risks – Update: this was discussed at

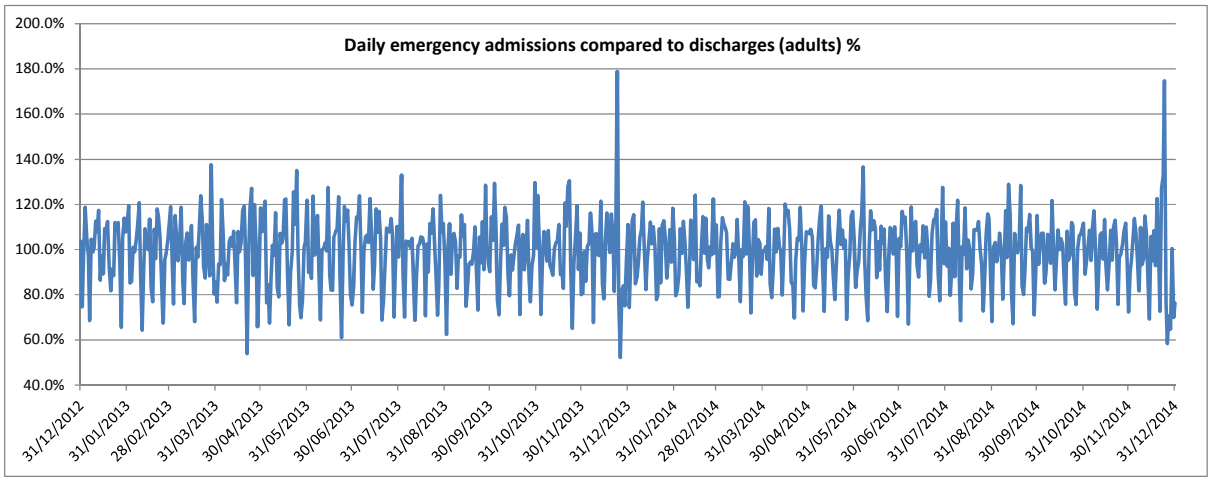
the Urgent Care Board on 30 December - 'Following an extensive discussion considering risk across all settings of care within the system, the UCB identified five key areas of greatest current risk (in no particular order):

- Lack of EMAS capacity resulting from volume/handover issues leading to patients waiting 'unsighted' in the community for a first response following initial telephone triage
- Overcrowding in ED/CDU leading to risk of high need patients being incorrectly prioritised and/or not being assessed and treated in line with their relative priority
- Handover delays for EMAS crews at LRI leading to risk of patients condition deteriorating while waiting
- Short notice cancellation of elective procedures as a result of bed availability resulting in patients (including cancer patients) deteriorating while waiting for treatment to be rescheduled
- Overstretched nursing and medical ward staff cover in UHL acute and LPT community hospital beds leading to harm from delays in care, treatment compliance and patient deconditioning'.

The Chief Nurse for East Leicestershire and Rutland CCG will co-ordinate pulling together and refining of these risks into a UCB risk log and this is going to the system resilience group on 5 January 2015.

Progress continues to be made with the UHL actions in the LLR action plan formulated in response to the Sturgess report, attached as appendix one. As of 5 January 2015, the four members of the EY management support team will be in place primarily working with clinical staff in ED, the assessment units and the base wards. Despite the activity that is taking place, little output progress is apparent.

Performance will only consistently improve when more patients are discharged than before and most importantly we need to see a change in the ratio of discharges to admissions. It is clear from the graph below that apart from Christmas Eve in 2013 and 2014, the daily emergency admission and discharge rate for adults track each other fairly consistently. Despite 11% more patients being discharged year to date compared to last year, the benefit of this has been completely offset by increasing admissions.



Real improvement requires external actions delivering outputs in parallel with internal actions delivering outputs. Locally and nationally the demand for emergency services is very high and we are not seeing the required movement on outputs.

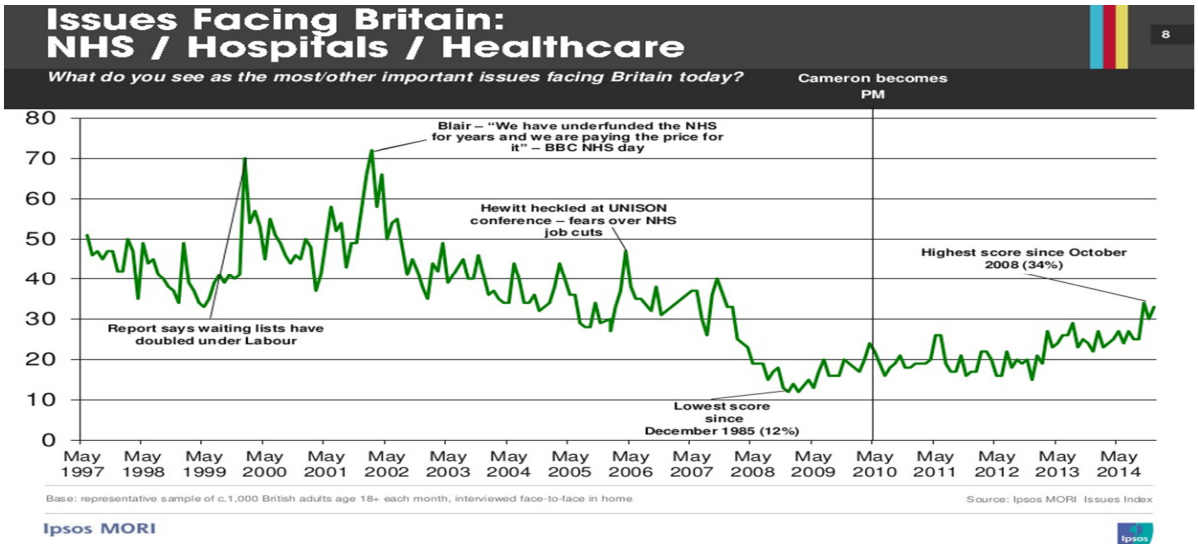
As detailed in the Sturgess report and in the last Trust Board papers, the actions taken must deliver:

- **Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department.
- **Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs.

- **Improving processes within Leicester's Hospitals** – improving the Emergency Department and patient flow within the hospitals to improve patient experience and ensure there is capacity in all areas.
- **Discharge processes across whole system** - ensuring there are simple discharge pathways with swift and efficient transfers of care

As requested by the Trust Board, the LLR urgent care dashboard is attached as appendix two.

Growing concerns about national performance are reflected in the most recent Ipsos Mori poll which show concerns about the NHS/ Hospitals and Healthcare reaching a six year high.

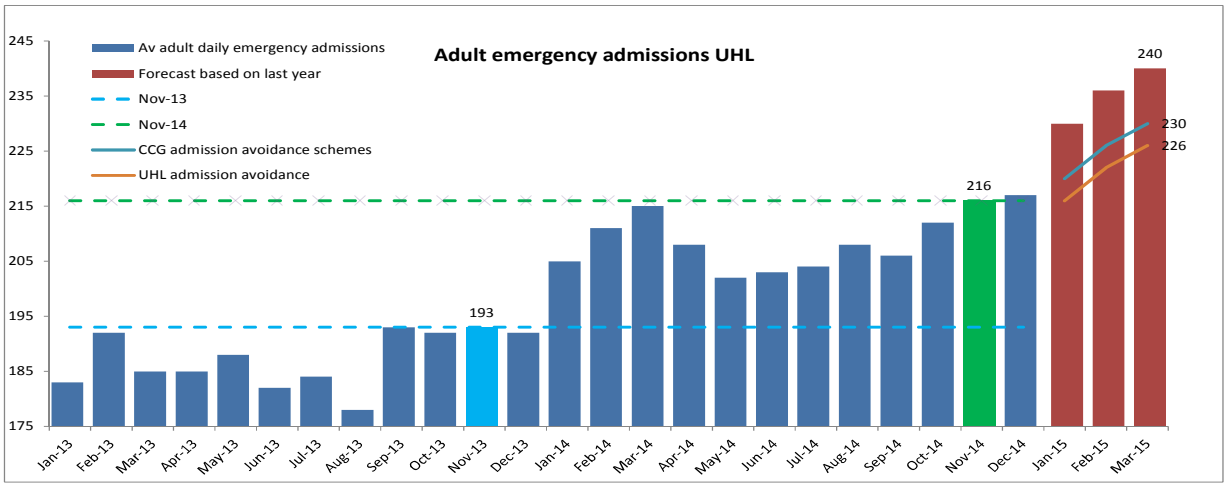


Source: https://www.ipsos-mori.com/researchpublications/researcharchive/3496/EconomistIpsos-MORI-December-2014-Issues-Index.aspx

Conclusion

The conclusions from the December Trust Board are still valid. To achieve sustainable improvement requires all parts of the health economy to improve. The fragile nature of the pathway means that slow adoption of improvements in one part of the health economy will hinder the overall improvement. We need to be ambitious for the level of improvement we require of each other and this is the intention of the new Operational Plan and its supporting arrangements.

Concerns remain about the rising level of admissions and plans to resolve this. If admissions rise at the same rate as last year, there will be 240 admissions per day in March 2015. We must therefore set challenging expectations for all parts of the health economy (including UHL) and work to ensure these expectations are rapidly met.



Recommendations

The Trust Board is recommended to:

- **Note** the contents of the report
- **Note** the actions taken since December's Trust Board
- **Note** the UHL update against the delivery of the new operational plan
- Seek **assurance** on UHL and LLR progress

Organisation	Improvement Requirement	Action(s)	KPI trajectory	Accountable lead	Delivery date	Operational delivery group	Status	Where closed, actions completed	Next Review Date
UHL	**Implement the Ambulatory Emergency Care strategy**	Re-implement acute physician GP phone triage (Newly added)	5% reduction in admissions (circa 4 patients per day)	Catherine Free	22-Dec-14	AMU subgroup of EQSG	4. On track	Plan was to trial from 22/12/14 but because of the requirement to open ward 42 at short notice whilst not shutting ward two and v high medical take meaning medical patients have been outlying across surgery, we have not had the doctors to implement this from 1700 to 2200. Bed bureau clinic are taking calls during the day. 1700 - 2200 action will be implemented 5/1/15	
UHL	**Implement the Ambulatory Emergency Care strategy**	1) Cohort six member of AEC network	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Dec-14	AMU subgroup of EQSG	5. Complete	Completed Member of network	
UHL	**Implement the Ambulatory Emergency Care strategy**	2) Select priority pathways for implementation	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Jan-15	AMU subgroup of EQSG	1. Not yet commenced	Information request in system	
UHL	**Implement the Ambulatory Emergency Care strategy**	3) Implement priority pathways	5% reduction in admissions (circa 4 patients per day)	Lee Walker	31-Mar-15	AMU subgroup of EQSG	1. Not yet commenced		
UHL	**Improve ambulance turnaround**	3) Continue to employ additional nurses to work in the assessment bay to minimise handover times	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	14-Dec-14	ED subgroup of EQSG	5. Complete	Completed Additional nurses have been employed and are now working in the assessment bays to minimise handover times.	
UHL	**Improve ambulance turnaround**	1) Work with EMAS and CCGs to introduce RFID as the sole data set	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	31-Dec-14	ED subgroup of EQSG	4. On track	Ongoing conversations about use of RFID vs CAD+ RM has emailed PB to ask for further confirmation of next actions.	
UHL	**Improve ambulance turnaround**	2) Use the new data set to agree the real scale of the problem	50% reduction in waits over 30 mins and 50% reduction in waits over one hour	Rachel Williams	31-Jan-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Improve front door (UCC/ED) interface/alignment**	1) Continue weekly clinical meetings with UCC team	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 14/1/15) This has been implemented and weekly reviews with UCC Clinical Director in place.	14-Jan-15
UHL	**Improve front door (UCC/ED) interface/alignment**	3) Ensure UCC is supported to manage the '30 min' rule	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 14/1/15) This has been implemented and weekly reviews with UCC clinical director in place.	14-Jan-15
UHL	**Improve front door (UCC/ED) interface/alignment**	5) Ensure ED is not used as an admission route by other specialities from UCC	90% of patients triaged within 20 minutes	Julie Dixon	14-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 14/1/15) This has been implemented and weekly reviews with UCC Clinical Director in place. Notes audit on 3 days' worth of ED & UCC data to be undertaken. Results will be used to agree future clinical pathways.	14-Jan-15
UHL	**Improve front door (UCC/ED) interface/alignment**	4) Support the UCC where possible to ensure 'construction handover' date for the UCC takes place on the 19/12 and the move date is 23/12	90% of patients triaged within 20 minutes	Jane Edyvean	31-Dec-14	ED subgroup of EQSG	5. Complete	Complete	
UHL	**Improve middle grade staffing resilience on AMU**	1) Review remuneration rates for tempory medical staff on AMU	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	31-Dec-14	AMU subgroup of EQSG	6. Complete and monthly review	Next action due (by 31/12/14) Verbal agreement for same renumeration as ED secured. Final documentation to be submitted.	31-Dec-14
UHL	**Improve middle grade staffing resilience on AMU**	2) Develop more resilient middle grade staffing model for AMU	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	31-Mar-15	AMU subgroup of EQSG	1. Not yet commenced		

UHL	**Improve the discharge process in medicine and cardio-respiratory**	3) Implement the long length of stay review process	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) This has been mandated. Initial audit completed. Reaudit to be completed.	31-Jan-15
UHL	**Improve the discharge process in medicine and cardio-respiratory**	6) All patients to have an EDD and CCD set at first review on base wards including criteria for nurse delegated discharge	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Next Actions Patient cards to be handed out/implemented (awaiting printing). Nurse delegated discharge plan in preparation. Audit of compliance to be undetaken in January post card implementation.	31/01/2015
UHL	**Improve the discharge process in medicine and cardio-respiratory**	4) Wards to generate a list of next morning discharges with TTOs written the prevous day	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	15-Jan-15	Base ward subgroup of EQSG	4. On track	Next Actions (Report due by 15/1/15) Diagnostic in progress. TTO and pharmacy planning meeting completed on 18/12/14.	15-Jan-15
UHL	**Improve the discharge process in medicine and cardio-respiratory**	7) Prioritise therapy and specialist input to expediate simple discharge	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	15-Jan-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the discharge process in medicine and cardio-respiratory**	8) Reskill ward staff to facilitate simple discharges	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	15-Jan-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the discharge process in medicine and cardio-respiratory**	9) Liberate nursing time to drive discharges	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	15-Jan-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the discharge process in medicine and cardio-respiratory**	2) Implement one stop ward rounds	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Jan-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the discharge process in medicine and cardio-respiratory**	5) Eliminate rebeds / failed discharges for non clinical reasons	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	28-Feb-15	Base ward subgroup of EQSG	4. On track		
UHL	**Improve the discharge process in medicine and cardio-respiratory**	1) Standardise the assertive MDT board round process seven days per week	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Mar-14	Base ward subgroup of EQSG	4. On track		
UHL	**Improve the resilience of ED processes**	1) Implement improvements to Gold Command	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	07-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 7/1/15) Gold command improvements implemented and running smoothly. Attendance to be monitored in January.	07-Jan-15
UHL	**Improve the resilience of ED processes**	6) Ensure ED is not used as an admission route by other specialities	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	14-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 14/1/15) This has been established and regularly being enforced.	14-Jan-15
UHL	**Improve the resilience of ED processes**	7) Ensure ED is supported to manage the '30 min' rule	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	14-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 14/1/15) Pilot of 1pm meeting with oncall teams is supporting this. CHUGs and ESM in agreement. MSS discussion required.	14-Jan-15

UHL	**Improve the resilience of ED processes**	2) Set up a weekly journey meeting which reviews delays in processes within the ED dept	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	31-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Reviews in place supported by tracker analysis to identify improvements.	31-Jan-15
UHL	**Improve the resilience of ED processes**	4) Ensure consistent application of floor management standard operating procedures (SOPs)	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Ben Teasdale	31-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) SOPs are being applied.	31-Jan-15
UHL	**Improve the resilience of ED processes**	11) Develop and enforce whole hospital response relating to ED exit block (i.e. poor flow)	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Andrew Furlong	15-Jan-15	ED subgroup of EQSG	4. On track	Monthly Review (Next review 15/01/15) Initial review of other hospital responses completed on 17/12/14. Draft UHL document has been completed and sent to CMGs for comment by 9 January 2015 and competion of one page template of specialty actions for each level of response to be completed by 15.1.15	31-Jan-15
UHL	**Improve the resilience of ED processes**	3) Address systematic delays identified in journey meetings (e.g. portering, transport)	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Julie Dixon	15-Jan-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the resilience of ED processes**	9) Refresh ED medical staffing recruitment plan	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Ben Teasdale/Rachael Williams	31-Jan-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the resilience of ED processes**	10) Implement ED SOPs relating to managing activity spikes and when there is exit block	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Ben Teasdale	31-Jan-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the resilience of ED processes**	5) Expand the use of EDU pathways	70% of time ED occupancy less than 55 and no more	Ben Teasdale/ Mark Williams	31-Mar-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Improve the resilience of ED processes**	8) Implement the 0800 'safety team'	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Catherine Free	31-Jan-15	ED subgroup of EQSG	1. Not yet commenced		
UHL	**Increase the proportion of GP bed referrals going directly to AMU**	4) Keep bed bureau clinic empty overnight enabling improved flow in the morning	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	14-Dec-14	AMU subgroup of EQSG	5. Complete	Completed Communication has been sent to staff regarding keeping Bed Buraeu empty. Bed Bureau has been empty (bar one occasion).	
UHL	**Increase the proportion of GP bed referrals going directly to AMU**	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Agreed with CCG. This is occuring.	31-Jan-15
UHL	**Increase the proportion of GP bed referrals going directly to AMU**	2) Ensure senior decision maker presence within acute medical clinic between 0900 and 1700 seven days a week	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Lee Walker	31-Jan-15	AMU subgroup of EQSG	1. Not yet commenced		
UHL	**Increase the proportion of GP bed referrals going directly to AMU**	3) Increasing bed capacity by three within the acute medical clinic (capital scheme)	Greater than 40% in Q3 and greater than 70% in Q4 of GP referrals go directly to AMU	Jane Edyvean	28-Feb-15	AMU subgroup of EQSG	1. Not yet commenced		

UHL	**Reduce bed occupancy on the base wards**	3) Increase consultant presence on short stay and key speciality base wards (34, 37 and 38) at the weekend	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	14-Dec-14	Base ward subgroup of EQSG	5. Complete	Completed Rota now in place and consultants are now present at weekends.	
UHL	**Reduce bed occupancy on the base wards**	1) All patients leaving the assessment unit must have a main diagnosis, plan and EDD	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Lee Walker	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) This has been mandated. Initial audit completed. Reaudit to be completed.	31-Jan-15
UHL	**Reduce bed occupancy on the base wards**	5) Implement peer review of ward rounds and long stay patients	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) This has been mandated. Peer review occuring and report to be shared internally to confirm improvements.	31-Jan-15
UHL	**Reduce bed occupancy on the base wards**	6) Ensure that patients 'sit out' or move to the discharge lounge asap and book ambulances when TTOs are complete	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Junior doctors working group and diagnostic in progress. Process mapping of transport pathway occuring.	31-Jan-15
UHL	**Reduce bed occupancy on the base wards**	7) Use metrics to identify high/ low achieving wards and support low achieving wards to improve	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Metrics and diagnostics being collated and to be carried out in January with full project team.	31-Jan-15
UHL	**Reduce bed occupancy on the base wards**	8) Ensure accuracy of real time bed state	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Gill Staton	31-Jan-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Reduce bed occupancy on the base wards**	2) Start base ward rounds now at 0830 and then move to 0800 start by 31/3 five days a week	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Mar-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Reduce bed occupancy on the base wards**	4) Establish the manpower, rota requirements and finances and necessary support staff for further extension of weekend consultant cover (links to seven day plan)	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Ian Lawrence	31-Mar-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Reduce bed occupancy on the base wards**	9) Develop plan to implement electronic bed management system	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Rachel Overfield	31-Mar-15	Base ward subgroup of EQSG	1. Not yet commenced		
UHL	**Reduce discharge delays caused by TTOs**	1) Increase the volume of TTOs completed the day before discharge	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Next Actions (Report due by 15/1/15) Diagnostic in progress.	15-Jan-15
UHL	**Reduce discharge delays caused by TTOs**	2) Prioritise pharmacy support to admission areas and base wards	Supports 5% (total) reduction in medical bed occupancy by the end of Q4	Maria McAuley	31-Dec-14	Base ward subgroup of EQSG	6. Complete and monthly review	Next Actions (Report due by 15/1/15) Diagnostic in progress.	15-Jan-15
UHL	**Reduce the time to assessment by a consultant on the AMU**	3) Start ward rounds at 0800	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Lee Walker	07-Dec-14	AMU subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 7/1/15) Implemented and observed majority of time but need to maintain monthly review.	07-Jan-15
UHL	**Reduce the time to assessment by a consultant on the AMU**	1) Validate and agree with CCG commissioning team that the data set is accurate	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Rachel Williams	31-Dec-14	AMU subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Agreed with CCG. This is occuring.	31-Jan-15

UHL	**Reduce the time to assessment by a consultant on the AMU**	2) Ensure consultant presence on AMU is continuous with roving ward rounds between 0800 and 2100 Monday to Friday and 0800 and 2000 at the weekend	Greater than 40% in Q3 and greater than 70% in Q4 of patients are seen by a consultant within six hours	Lee Walker	31-Dec-14	AMU subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) Continuous consultant presence implemented.	31-Jan-15
UHL	**Review ED staffing**	1) Review existing ED staffing to ensure optimum balance of capacity and demand (faciliated with simulation)	70% of time ED occupancy less than 55 and no more than one hour wait to be seen time	Ben Teasdale	31-Dec-14	ED subgroup of EQSG	6. Complete and monthly review	Monthly Review (Next review 31/1/15) staffing changes made in Paeds as agreed. Initial simulation meeting completed 17/12/15. Further modelling to take place as part of the simulation work to test optimum staffing levels.	31-Jan-15

Appendix Two

URGENT CARE

DASHBOARD REPORT

WEEK 38

BASE WARDS

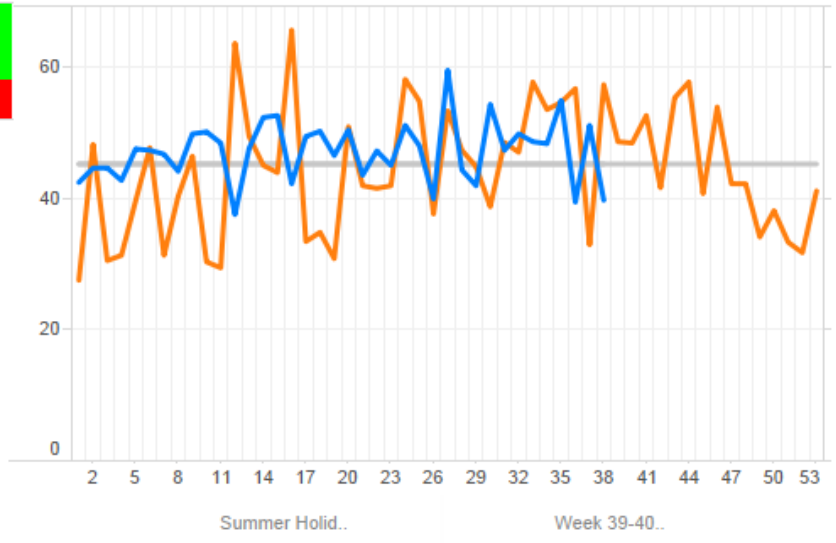
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

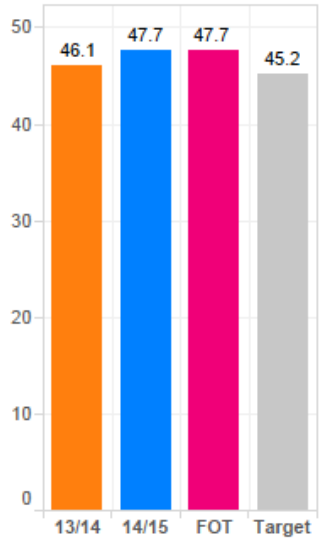
- (•) Base Wards
- ( ) Discharge
- ( ) Emergency Department and Admission Units
- ( ) Inflow

	13/14	14/15	FOT	Target	Variance from Target
UHL EM 65+ <4 Days LOS by %	46.1	47.7	47.7	45.2	5.5%
UHL EM 65+ with LOS 10+	8,385	5,372	7,550	7,966	-5.2%
UHL EM <65 <4 Days LOS by %	78.3	74.2	74.2	75.8	-2.1%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	36.2	37.5	43.8	44.8	39.8	48.2	46	53	48.6	52.6	44	37.5	44.4
2014/15	43.9	46.3	47.9	49.1	46.6	49.8	48.6	48	48.9				47.7
Target	45.2	45.2	45.2	45.2	45.2	45.2	45.2	45.2	45.2				45.2
Variance by %	-2.9	2.4	6.0	8.6	3.1	10.2	7.5	6.2	8.2				5.5

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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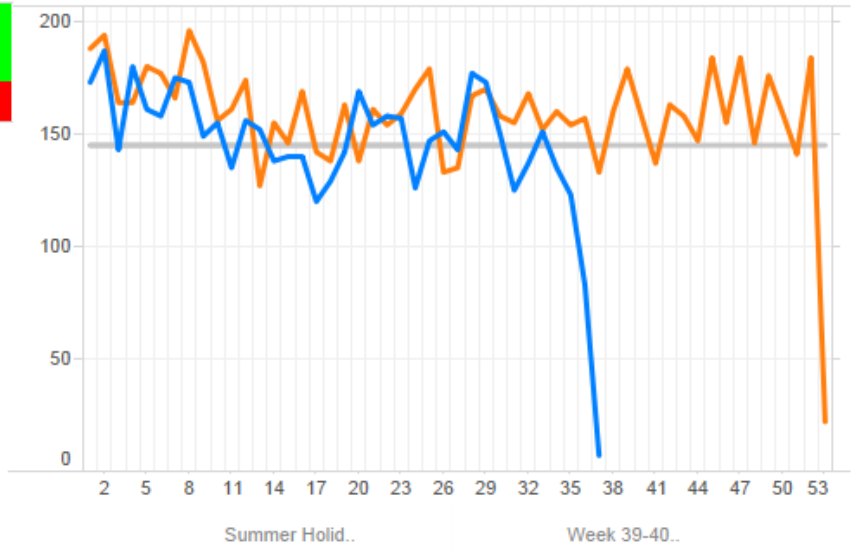
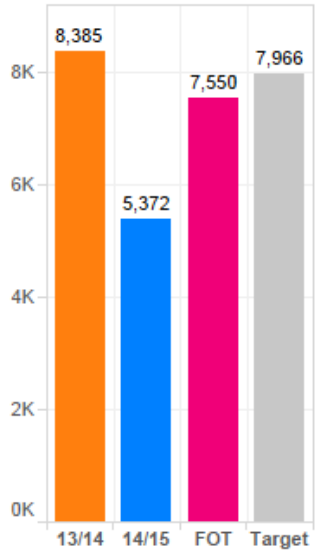
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	751	828	650	662	679	684	699	683	701	683	656	722	8,398
2014/15	727	735	635	595	681	619	697	578	105				5,372
Target	664	664	664	664	664	664	664	664	664				664
Variance by %	9.5	10.7	-4.4	-10.4	2.6	-6.8	5.0	-13.0	-84.2				709.0

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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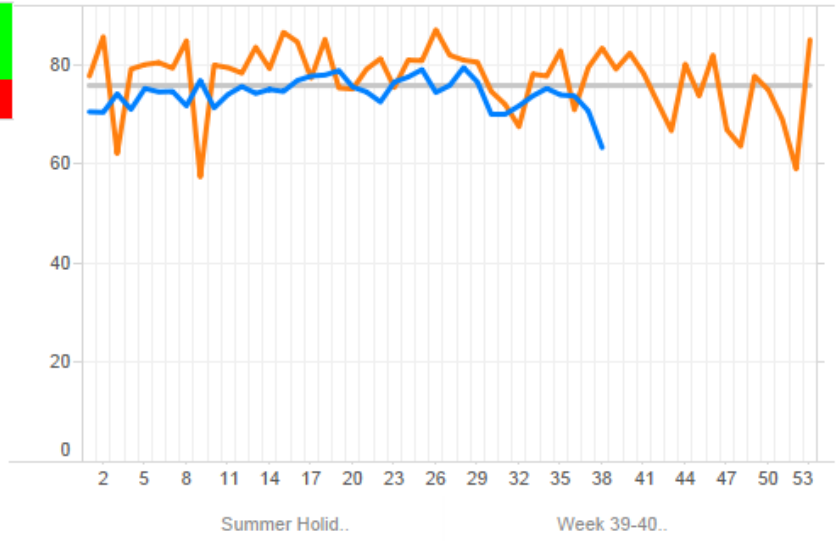
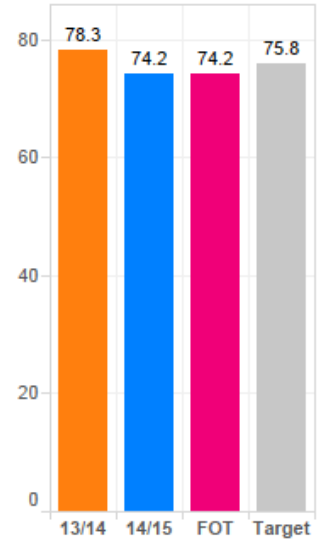
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	78	77.1	73.9	82.5	78.4	82.7	78.4	74.3	79.5	74.7	77.6	68.7	77.2
2014/15	72.1	74.5	74.6	76.8	76.3	75.4	73.6	72.6	71.3				74.2
Target	75.8	75.8	75.8	75.8	75.8	75.8	75.8	75.8	75.8				75.8
Variance by %	-4.9	-1.7	-1.6	1.3	0.7	-0.5	-2.9	-4.2	-5.9				-2.1

DISCHARGE

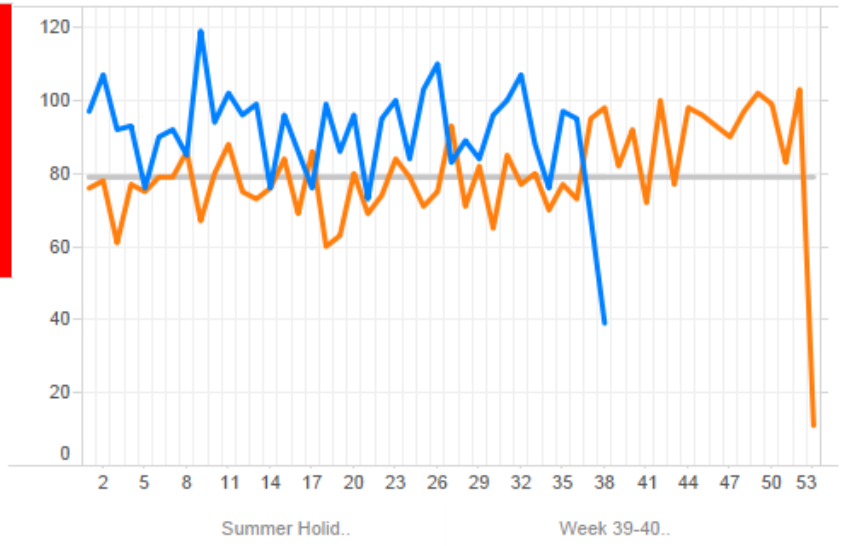
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

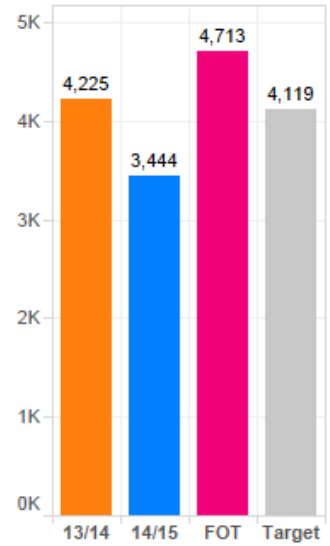
- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance rom Target
30 Days Medical Readmissions 65+	4,225	3,444	4,713	4,119	14.4%
30 Days Medical Readmissions <65	2,438	1,972	2,699	2,377	13.5%
DTOC days delayed up to census date	12,196	9,524	13,033	10,976	18.7%
DTOC Patients Delayed by %	4.4	4.8	4.8	3.5	37.1%
EM 30 Days Medical Readmissions	6,663	5,416	7,411	6,496	14.1%
UHL EM Discharged to Admitting Address by %	81.4	84	84	89.4	-6.0%
UHL Non Elective Pre-Midday Discharges by %	17.7	17.6	17.6	25	-29.6%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	320	343	331	345	307	333	355	324	376	400	376	415	4,225
2014/15	415	403	424	392	376	427	411	383	213				3,444
Target	343	343	343	343	343	343	343	343	343				343
Variance by %	21.0	17.5	23.6	14.3	9.6	24.5	19.8	11.7	-37.9				904.1

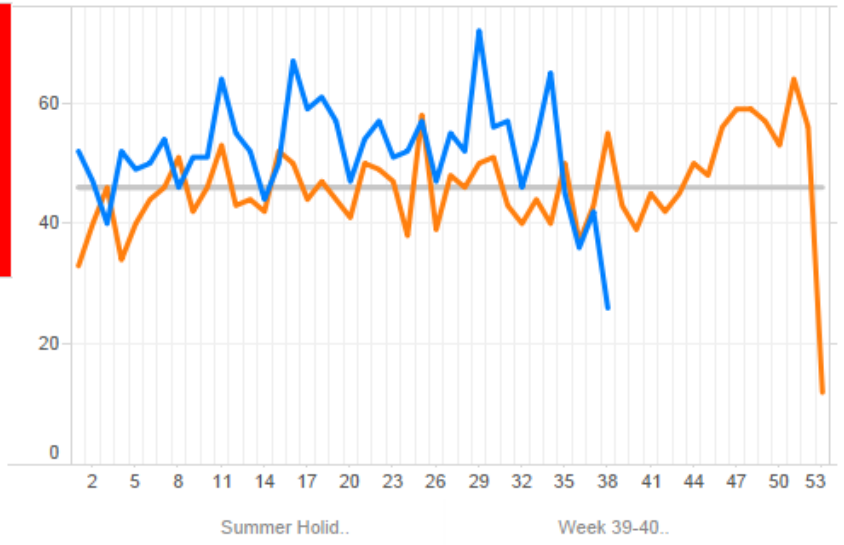
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

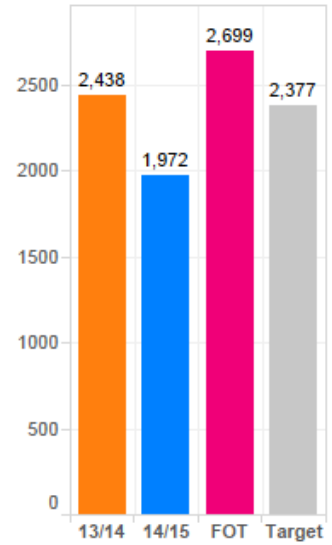
- ○ Base Wards
- ◉ Discharge
- ○ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance rom Target
30 Days Medical Readmissions 65+	4,225	3,444	4,713	4,119	14.4%
30 Days Medical Readmissions <65	2,438	1,972	2,699	2,377	13.5%
DTOC days delayed up to census date	12,196	9,524	13,033	10,976	18.7%
DTOC Patients Delayed by %	4.4	4.8	4.8	3.5	37.1%
EM 30 Days Medical Readmissions	6,663	5,416	7,411	6,496	14.1%
UHL EM Discharged to Admitting Address by %	81.4	84	84	89.4	-6.0%
UHL Non Elective Pre-Midday Discharges by %	17.7	17.6	17.6	25	-29.6%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	164	207	191	207	207	193	220	181	195	196	224	253	2,438
2014/15	213	212	238	249	238	230	256	228	108				1,972
Target	198	198	198	198	198	198	198	198	198				198
Variance by %	7.6	7.1	20.2	25.8	20.2	16.2	29.3	15.2	-45.5				896.0
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ◉ Discharge
- ○ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance from Target
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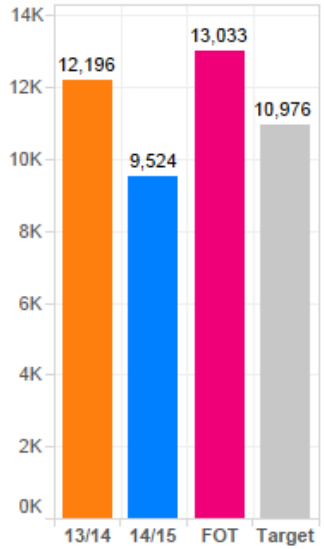
Weekly Trend against 2014/15 Target

Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
2014/15	1,183	1,215	754	1,021	754	881	1,271	1,585	860	9,524

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
■	■	■	■	■	■	■	■	■

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- (•) Discharge
- Emergency Department and Admission Unit
- Inflow

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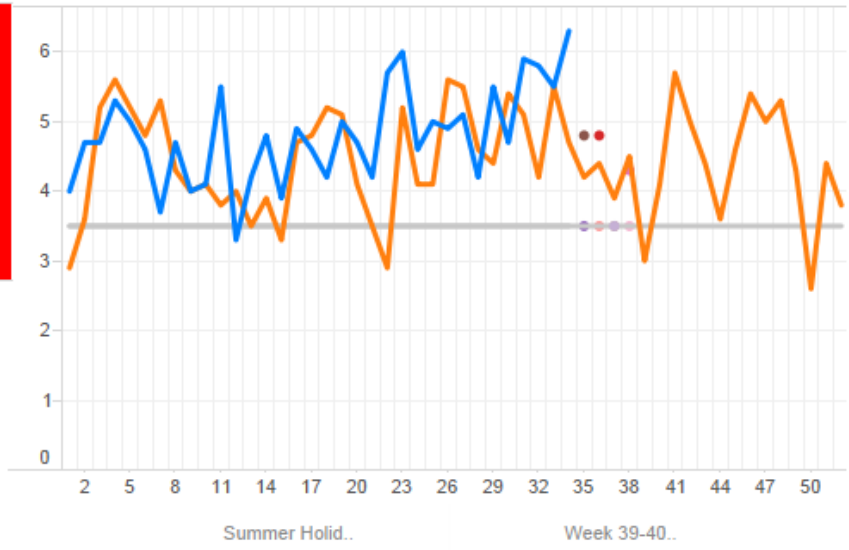

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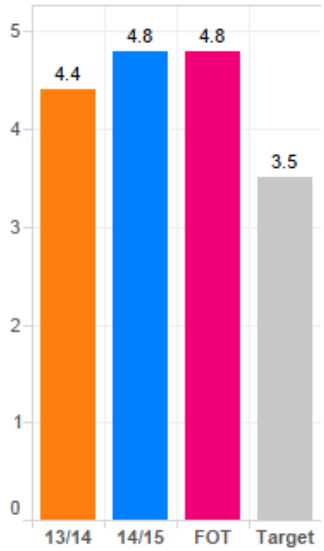

Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	4.3	4.7	3.8	4.2	4.2	4.8	5	4.7	3.9	4.6	5.1	3.8	4.4
2014/15	4.7	4.4	4.3	4.5	4.9	5.1	5.1	5.9					4.8
2014/16								4.8					4.8
Variance by %	34.3	25.7	22.9	28.6	40.0	45.7	45.7	68.6					37.1
2014/15								4.8					

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ◉ Discharge
- ○ Emergency Department and Admission Units
- ○ Inflow

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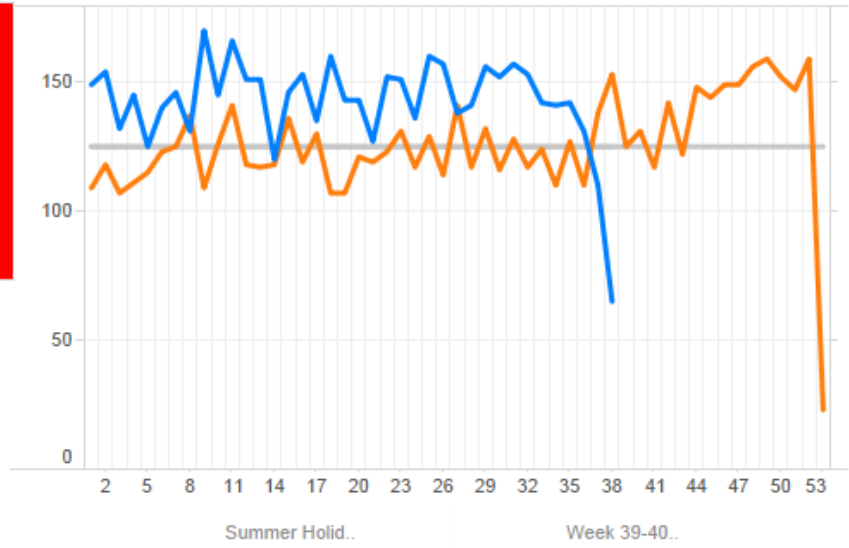
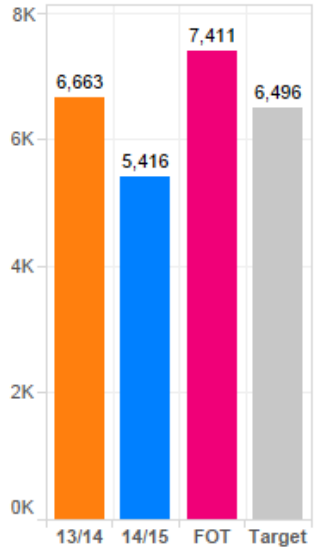


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	484	550	522	552	514	526	575	505	571	596	600	668	6,663
2014/15	628	615	662	641	614	657	667	611	321				5,416
Target	541	541	541	541	541	541	541	541	541				541
Variance by %	16.1	13.7	22.4	18.5	13.5	21.4	23.3	12.9	-40.7				901.1
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ◉ Discharge
- ○ Emergency Department and Admission Units
- ○ Inflow

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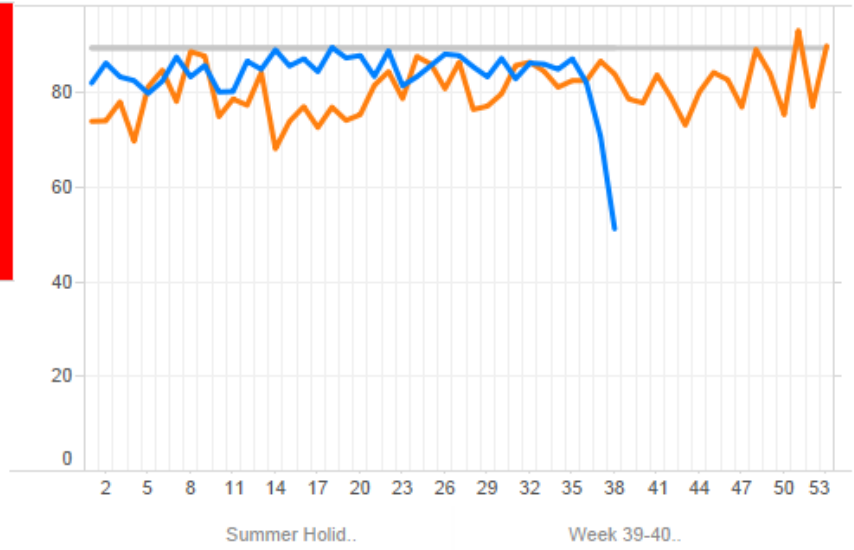
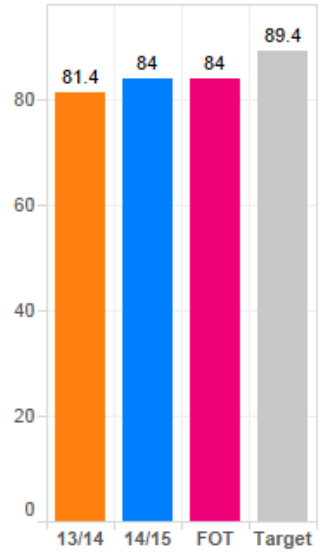


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	77	82.6	80.4	73.5	78.1	85.3	79.2	84.4	81.8	80.2	81.6	85	80.9
2014/15	81.6	85.1	83.3	87.8	86.2	86.5	84.6	85.5	73.3				84
Target	89.4	89.4	89.4	89.4	89.4	89.4	89.4	89.4	89.4				89.4
Variance by %	-8.7	-4.8	-6.8	-1.8	-3.6	-3.2	-5.4	-4.4	-18.0				-6.0

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ◉ Discharge
- ○ Emergency Department and Admission Units
- ○ Inflow

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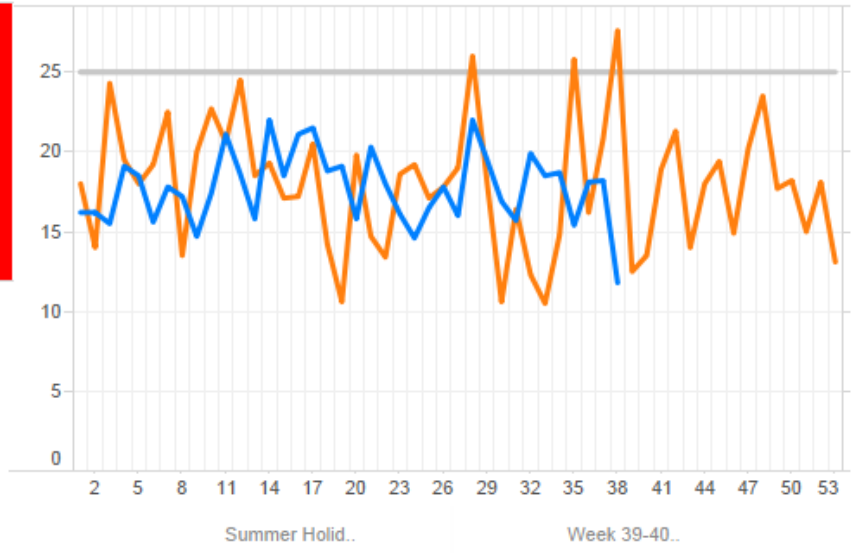
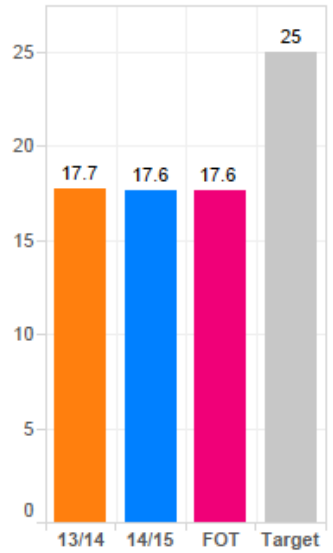
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	17.9	17.7	23.1	18	15.2	16.3	18.2	15.1	19.8	17.4	19.5	17.1	17.9
2014/15	17.2	16.8	17.3	19.6	20.2	15.3	18.5	17.9	15.4				17.6
Target	25	25	25	25	25	25	25	25	25				25
Variance by %	-31.2	-32.8	-30.8	-21.6	-19.2	-38.8	-26.0	-28.4	-38.4				-29.6

EMERGENCY DEPARTMENTS AND ADMISSION UNITS

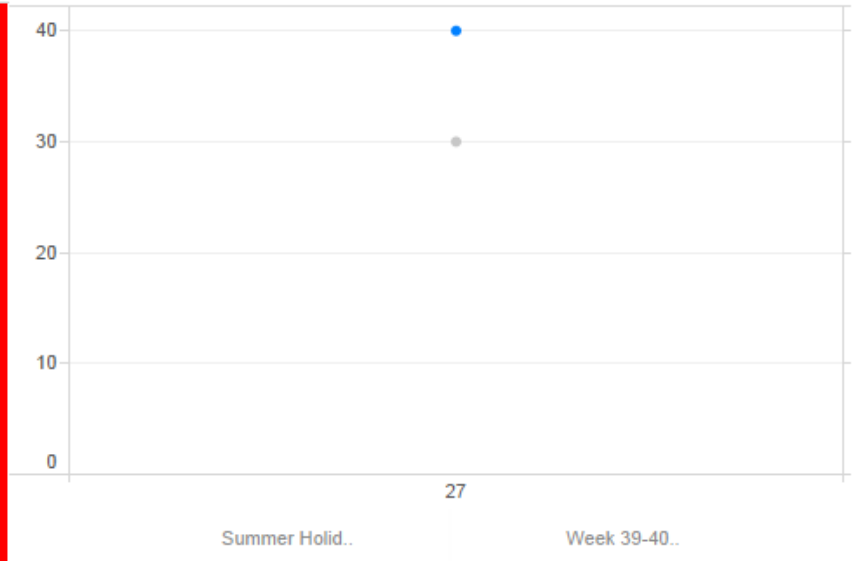
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

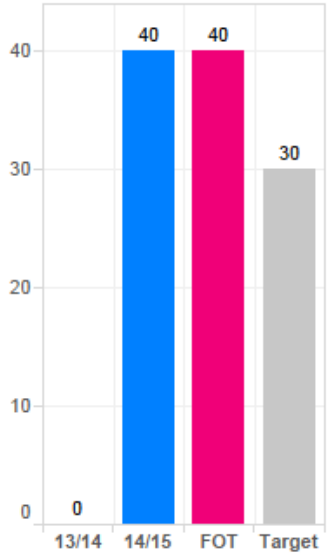
- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance rom Target
ED occupancy is above 55 pts by %	0	40	40	30	33.3%
Empty beds in AMU at 6pm	0	4	4	8	-50.0%
Medical gap in ED workforce	0	15	15	7	114.3%
Nursing gap in ED workforce	0	10	10	5	100.0%
UHL AE 4 hrs Admitted by %	55.9	59	59	95	-37.9%
UHL AE 4 hrs by %	90.5	90.5	90.5	95	-4.7%
UHL AE 4 hrs Non-Admitted by %	91.5	91.1	91.1	95	-4.1%
UHL AE by % Nurse Led Assessment <20 Mins..	40.2	35	35	44.2	-20.8%
UHL AE Waiting in for Admission at 8am	0	7	7	4	75.0%
UHL EM Falls 65+	2,073	1,471	2,013	1,866	7.9%
UHL EM Admissions	75,029	61,732	84,475	71,278	18.5%
UHL EM via AE	38,265	30,226	41,362	36,352	13.8%
UHL EM via Bed Bureau	11,639	9,206	12,598	11,057	13.9%
UHL EM via Consultant (OP)	2,274	1,791	2,451	2,160	13.5%
UHL EM via GP	8,018	6,130	8,388	7,617	10.1%
UHL EM via GP/Bed Bureau with 0 LoS	5,710	4,247	5,812	5,139	13.1%
UHL EM via Other Means	14,833	14,379	19,677	14,091	39.6%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	40	40

Sep

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance from Target
ED occupancy is above 55 pts by %	0	40	40	30	33.3%
Empty beds in AMU at 6pm	0	4	4	8	-50.0%
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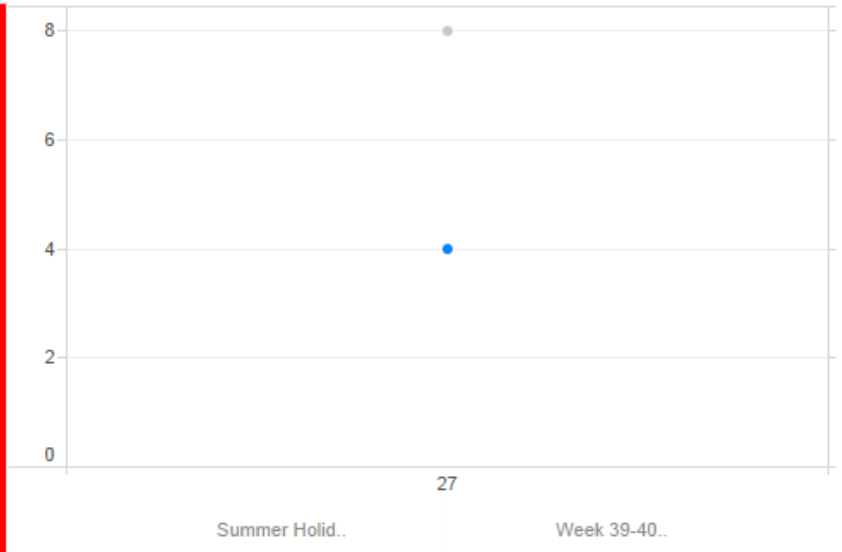
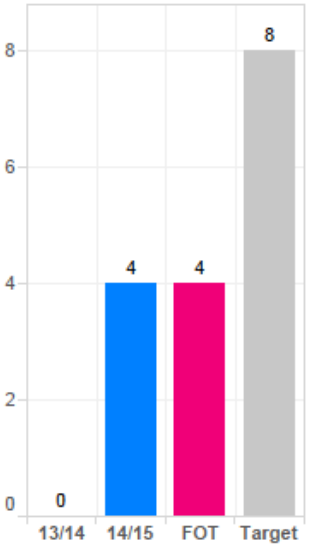
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	4	4

Sep

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance from Target
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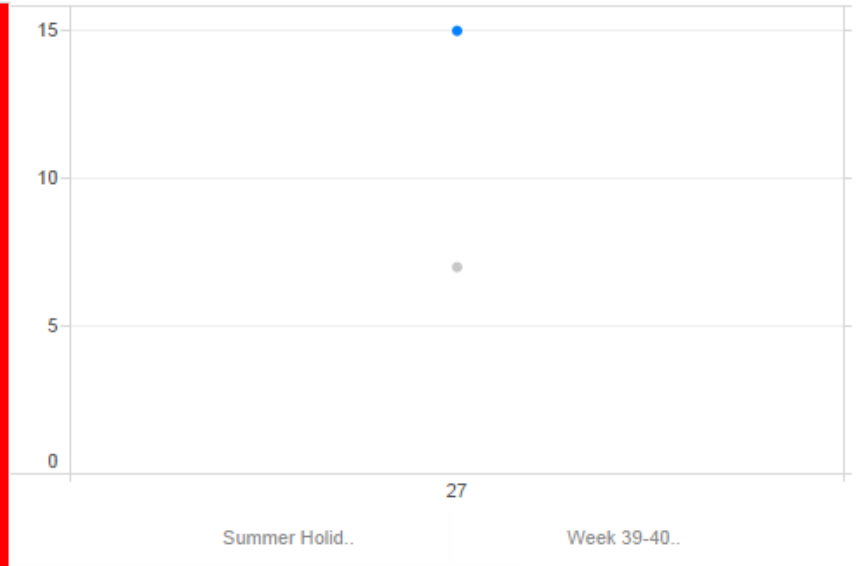

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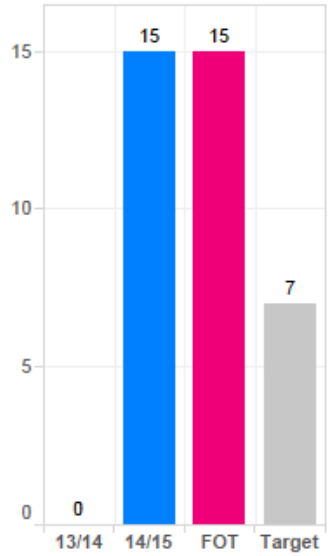

Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	15	15

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

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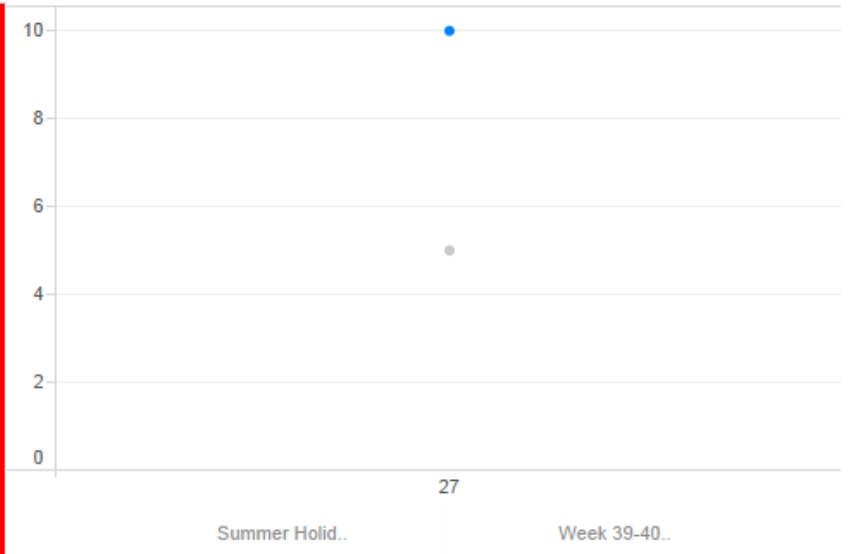
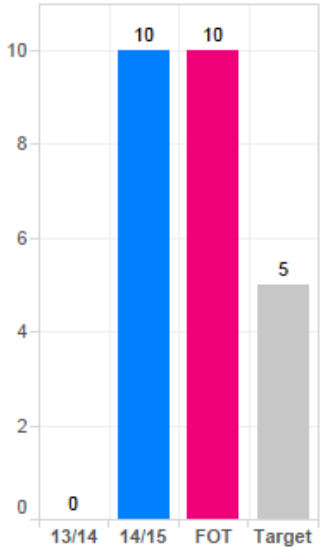


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	10	10

Sep

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance from Target
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Empty beds in AMU at 6pm	0	4	4	8	-50.0%
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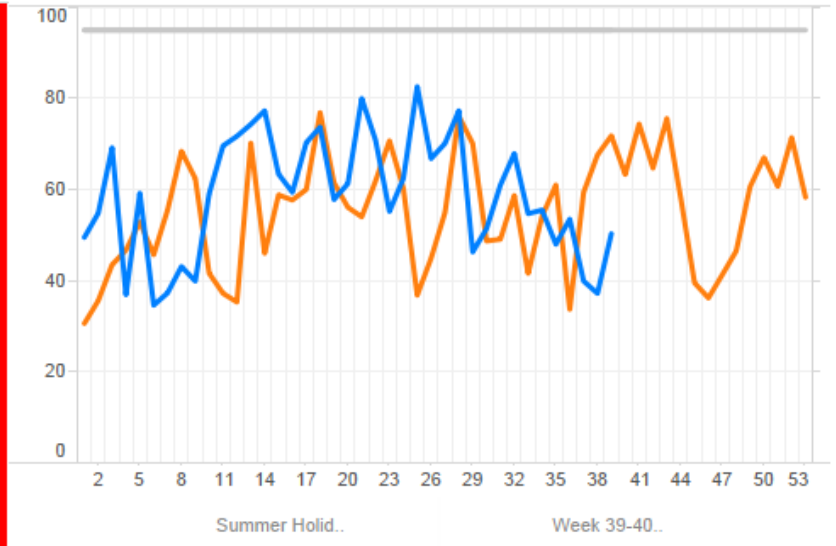
Weekly Trend against 2014/15 Target



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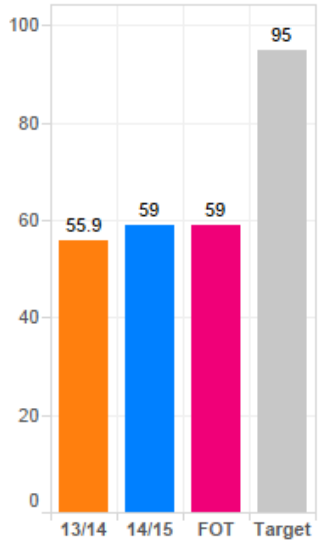

Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	38.4	62	47.8	58.7	61.5	56.6	60.3	52.3	59.8	69.6	42.2	60.1	55.9
2014/15	53.3	44.3	62.1	69.7	68.1	68.1	59.7	60.3	44				59
Target	95	95	95	95	95	95	95	95	95				95
Variance by %	-43.9	-53.4	-34.6	-26.6	-28.3	-28.3	-37.2	-36.5	-53.7				-37.9

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
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- Emergency Department and Admission Units
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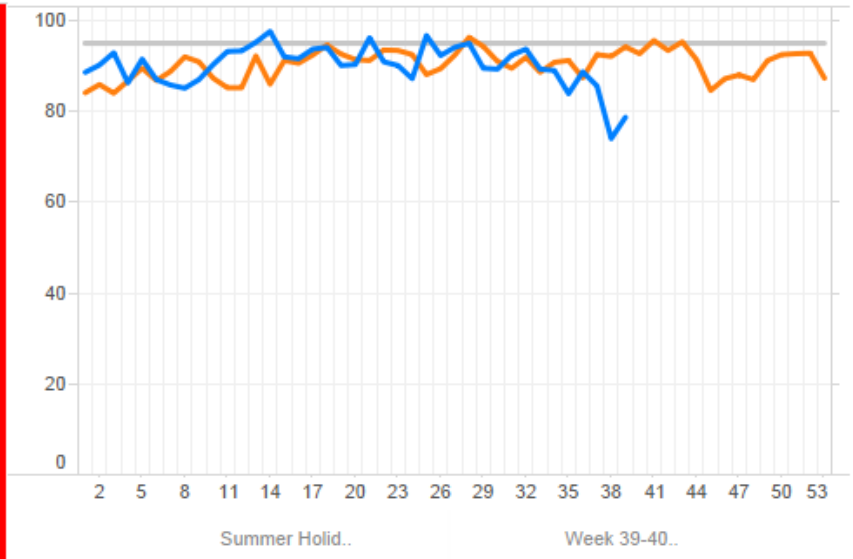
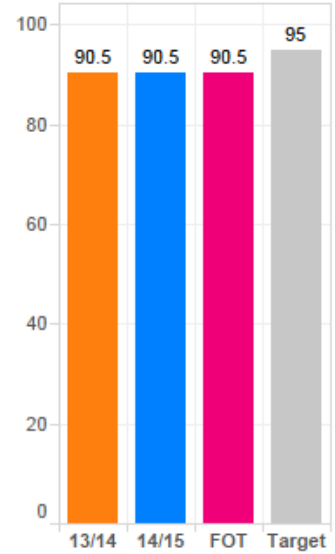


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	85.2	90.6	88	90.5	92.7	91.8	93.2	89.8	91.8	94.2	87.4	90.3	90.5
2014/15	90.2	87.5	92.4	93.8	92.5	91.7	92	91.3	81.1				90.5
Target	95	95	95	95	95	95	95	95	95				95
Variance by %	-5.1	-7.9	-2.7	-1.3	-2.6	-3.5	-3.2	-3.9	-14.6				-4.7

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
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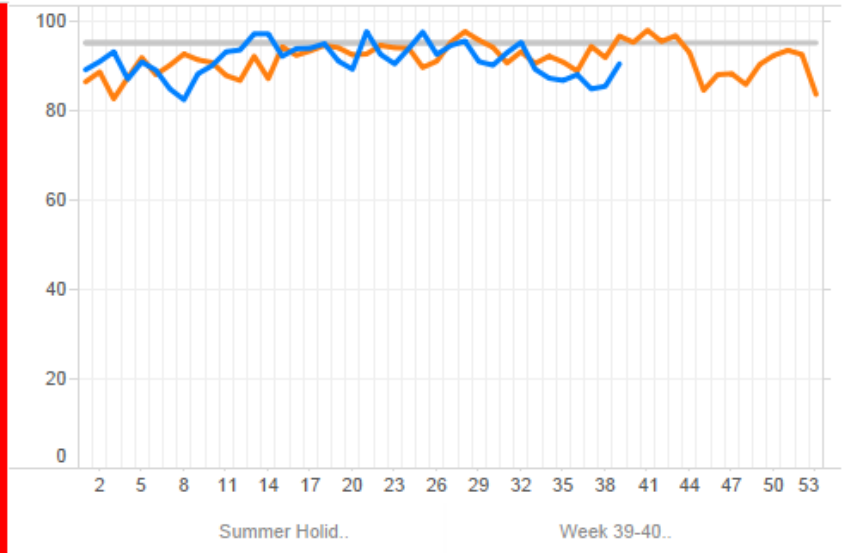
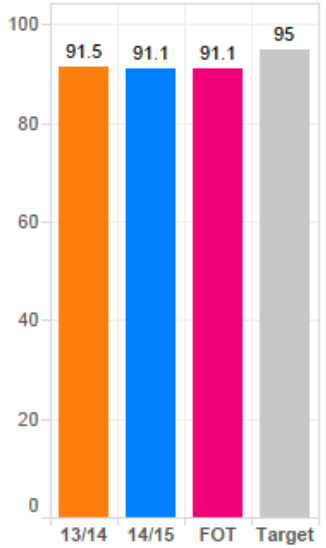


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	86.6	91.5	89.5	91.6	93.7	93.4	94.9	90.6	92.9	96.4	87.7	89	91.5
2014/15	90.6	86.6	92.1	94.7	92.6	93.1	92.8	91.2	86.3				91.1
Target	95	95	95	95	95	95	95	95	95				95
Variance by %	-4.6	-8.8	-3.1	-0.3	-2.5	-2.0	-2.3	-4.0	-9.2				-4.1

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
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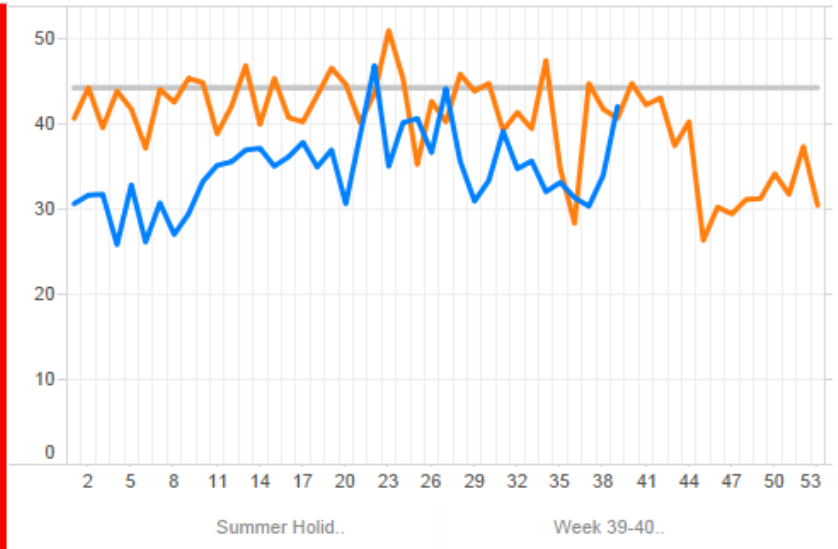
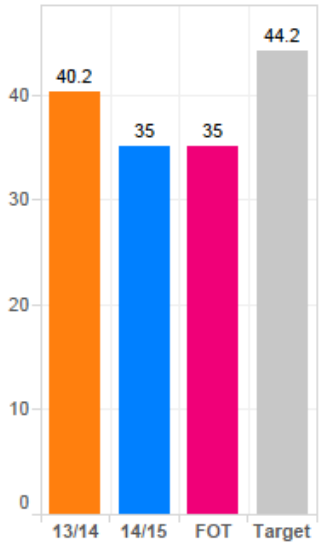


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	41.4	42.3	44	41.5	44.1	43.3	43.3	39.9	39.7	40.3	31.8	32.2	40.2
2014/15	31.3	29.1	33.4	36.1	35.6	43.2	33.7	37.3	33.5				35
Target	44.2	44.2	44.2	44.2	44.2	44.2	44.2	44.2	44.2				44.2
Variance by %	-29.2	-34.2	-24.4	-18.3	-19.5	-2.3	-23.8	-15.6	-24.2				-20.8

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
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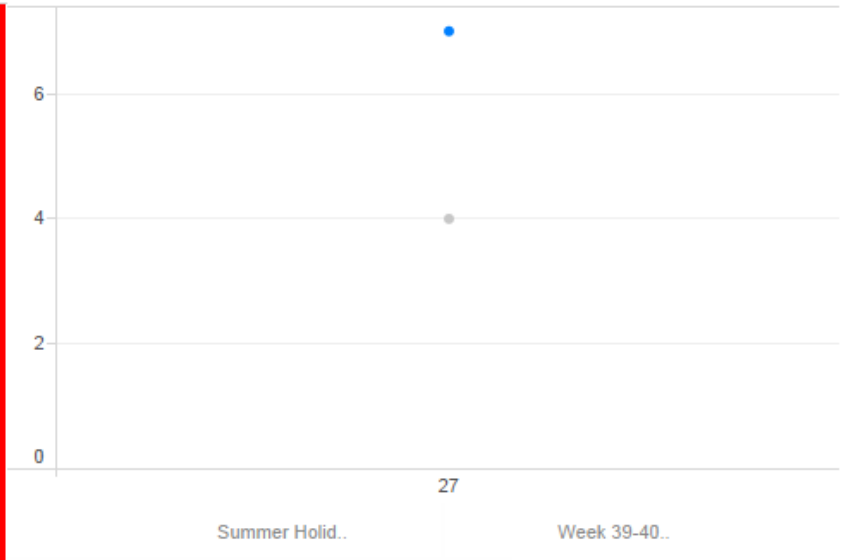

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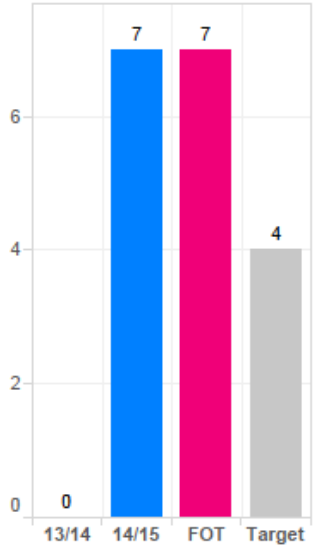

Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	7	7

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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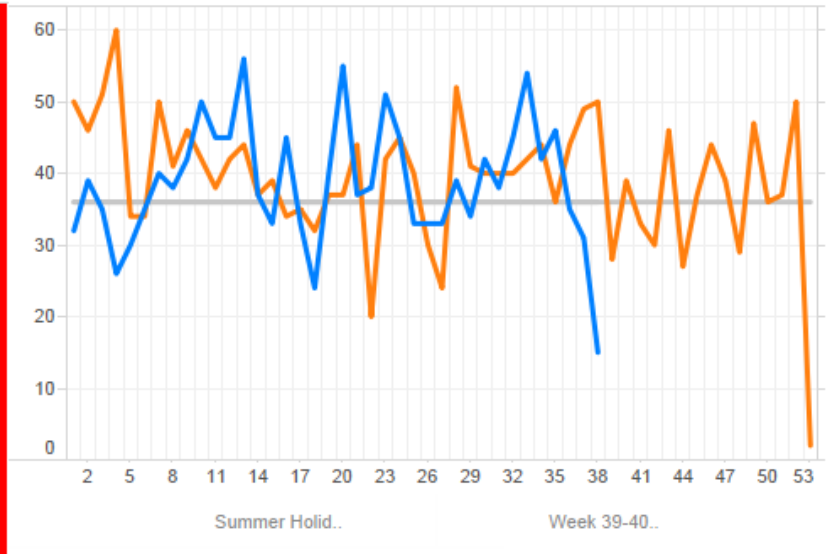

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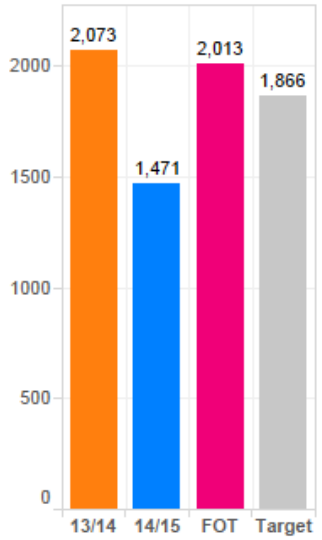

Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	215	189	174	159	153	168	179	170	188	152	154	175	2,076
2014/15	138	170	205	162	170	180	167	195	84				1,471
Target	155	155	155	155	155	155	155	155	155				155
Variance by %	-11.0	9.7	32.3	4.5	9.7	16.1	7.7	25.8	-45.8				849.0

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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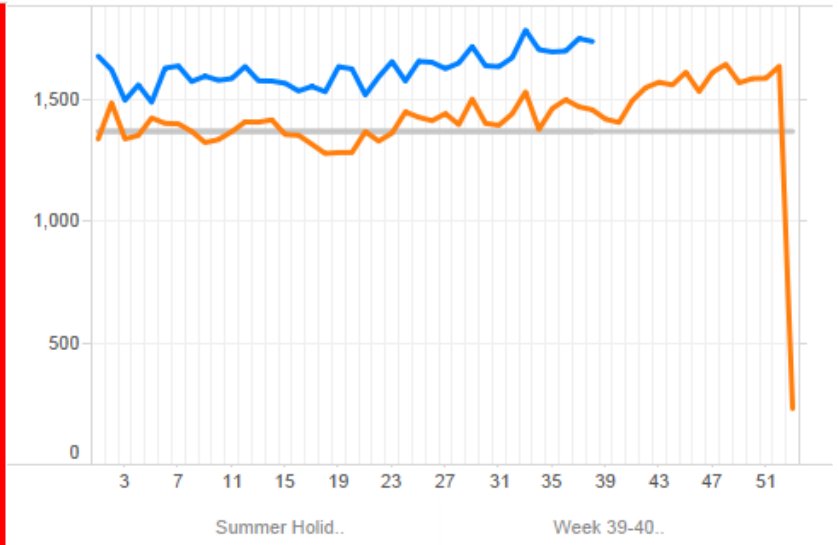

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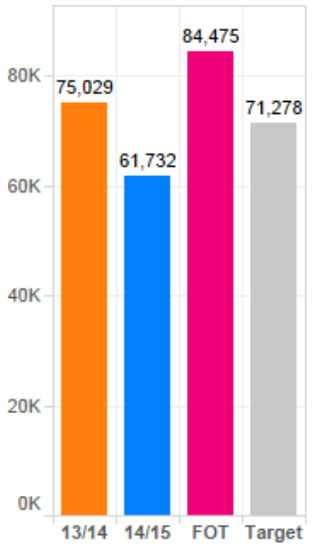

Monthly Values and Variance against the 2014/15 Target

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2013/14	5,945	6,197	5,834	6,041	5,795	6,043	6,364	6,211	6,466	6,797	6,391	6,990	75,074
2014/15	6,836	7,029	6,822	6,925	6,996	7,014	7,418	7,259	5,433				61,732
Target	5,940	5,940	5,940	5,940	5,940	5,940	5,940	5,940	5,940				5,940
Variance by %	15.1	18.3	14.8	16.6	17.8	18.1	24.9	22.2	-8.5				939.3
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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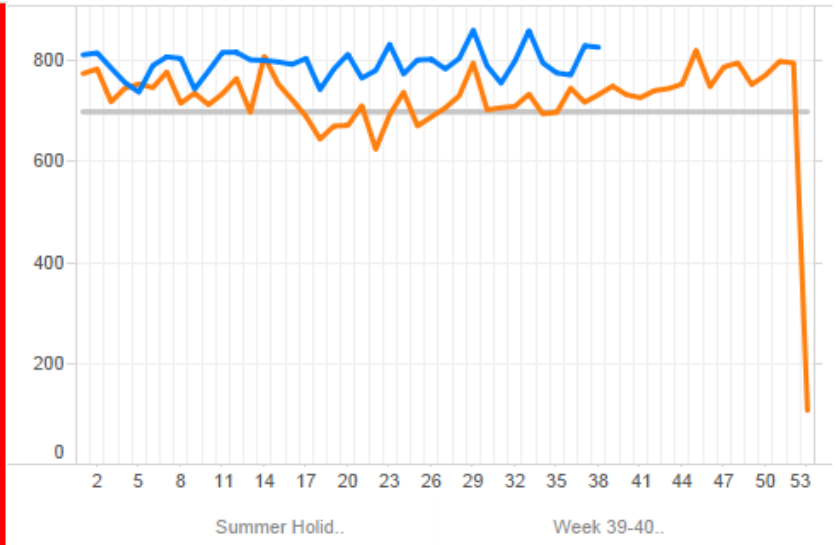
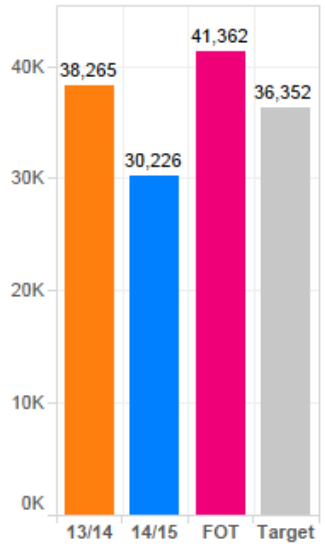
UHL EM Falls 65+	2,073	1,471	2,013	1,866	7.9%
UHL EM Admissions	75,029	61,732	84,475	71,278	18.5%
UHL EM via AE	38,265	30,226	41,362	36,352	13.8%
UHL EM via Bed Bureau	11,639	9,206	12,598	11,057	13.9%
UHL EM via Consultant (OP)	2,274	1,791	2,451	2,160	13.5%
UHL EM via GP	8,018	6,130	8,388	7,617	10.1%
UHL EM via GP/Bed Bureau with 0 LoS	5,710	4,247	5,812	5,139	13.1%
UHL EM via Other Means	14,833	14,379	19,677	14,091	39.6%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	3,227	3,327	3,112	3,254	2,954	2,974	3,233	3,053	3,268	3,294	3,125	3,445	38,266
2014/15	3,375	3,477	3,421	3,503	3,480	3,419	3,589	3,439	2,523				30,226
Target	3,029	3,029	3,029	3,029	3,029	3,029	3,029	3,029	3,029				3,029
Variance by %	11.4	14.8	12.9	15.6	14.9	12.9	18.5	13.5	-16.7				897.9
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance from Target
ED occupancy is above 55 pts by %	0	40	40	30	33.3%
Empty beds in AMU at 6pm	0	4	4	8	-50.0%
Medical gap in ED workforce	0	15	15	7	114.3%
Nursing gap in ED workforce	0	10	10	5	100.0%
UHL AE 4 hrs Admitted by %	55.9	59	59	95	-37.9%
UHL AE 4 hrs by %	90.5	90.5	90.5	95	-4.7%
UHL AE 4 hrs Non-Admitted by %	91.5	91.1	91.1	95	-4.1%
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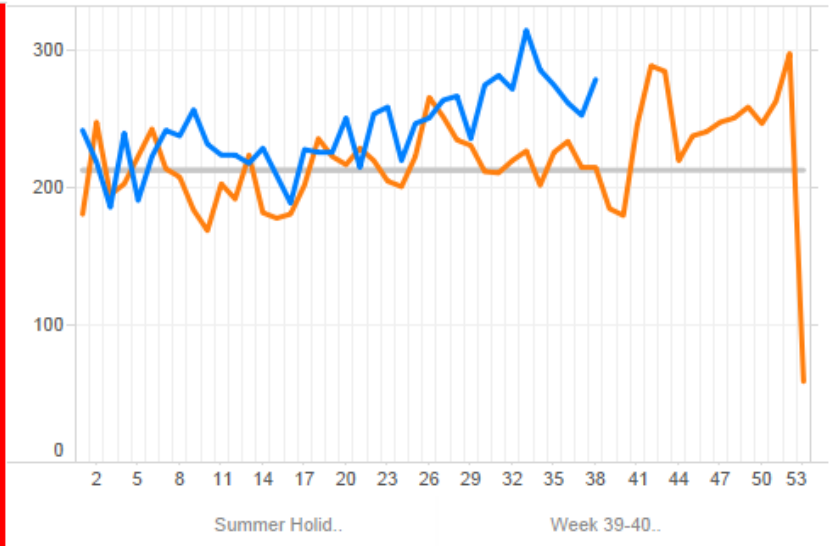
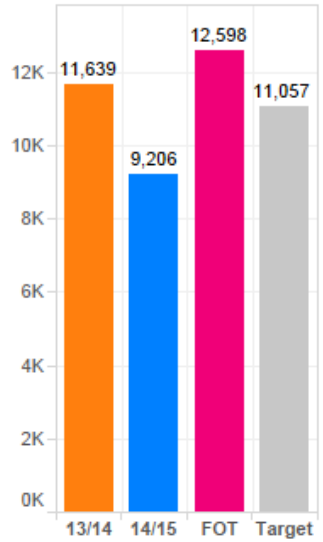
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	898	979	810	861	987	954	1,033	925	935	1,129	961	1,167	11,639
2014/15	963	1,018	955	960	1,026	1,065	1,176	1,201	842				9,206
Target	921	921	921	921	921	921	921	921	921				921
Variance by %	4.6	10.5	3.7	4.2	11.4	15.6	27.7	30.4	-8.6				899.6
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
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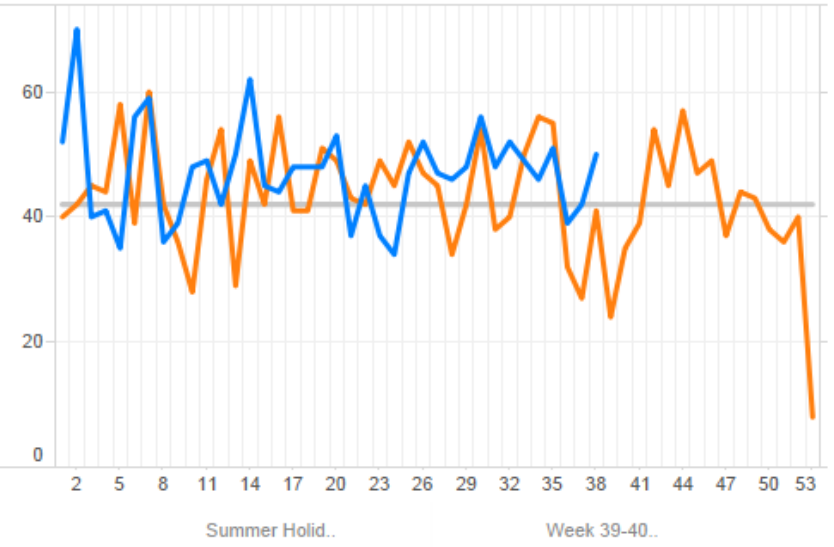
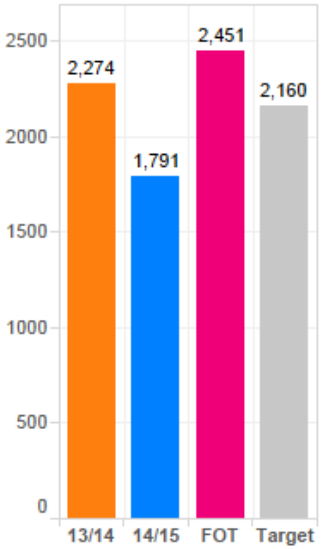


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	201	204	158	216	197	201	199	208	141	212	176	167	2,280
2014/15	221	202	194	231	191	189	229	195	139				1,791
Target	180	180	180	180	180	180	180	180	180				180
Variance by %	22.8	12.2	7.8	28.3	6.1	5.0	27.2	8.3	-22.8				895.0
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

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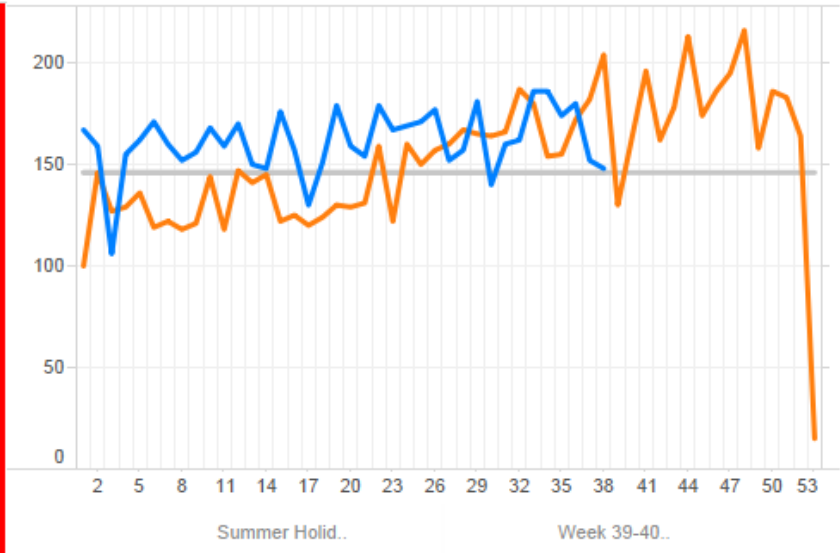
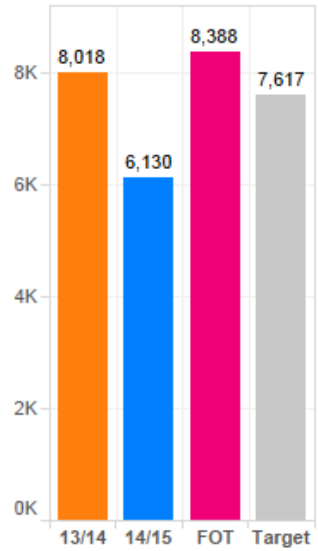
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	547	547	574	571	604	635	735	718	757	816	772	741	8,017
2014/15	645	704	686	687	708	740	710	739	511				6,130
Target	635	635	635	635	635	635	635	635	635				635
Variance by %	1.6	10.9	8.0	8.2	11.5	16.5	11.8	16.4	-19.5				865.4
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

	13/14	14/15	FOT	Target	Variance from Target
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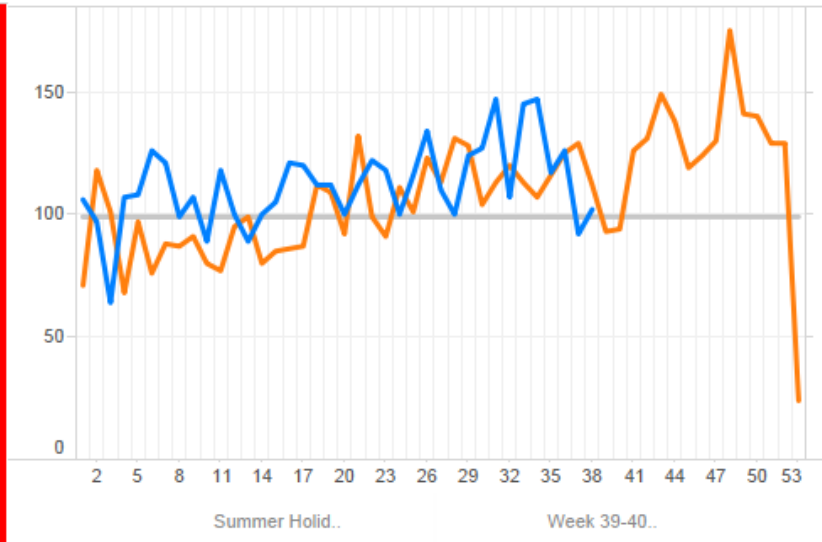
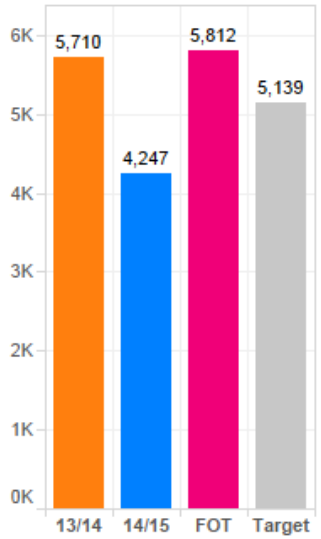
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	389	390	369	389	487	447	544	479	500	583	547	585	5,709
2014/15	413	506	412	502	482	499	538	558	337				4,247
Target	428	428	428	428	428	428	428	428	428				428
Variance by %	-3.5	18.2	-3.7	17.3	12.6	16.6	25.7	30.4	-21.3				892.3

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ◉ Emergency Department and Admission Units
- ○ Inflow

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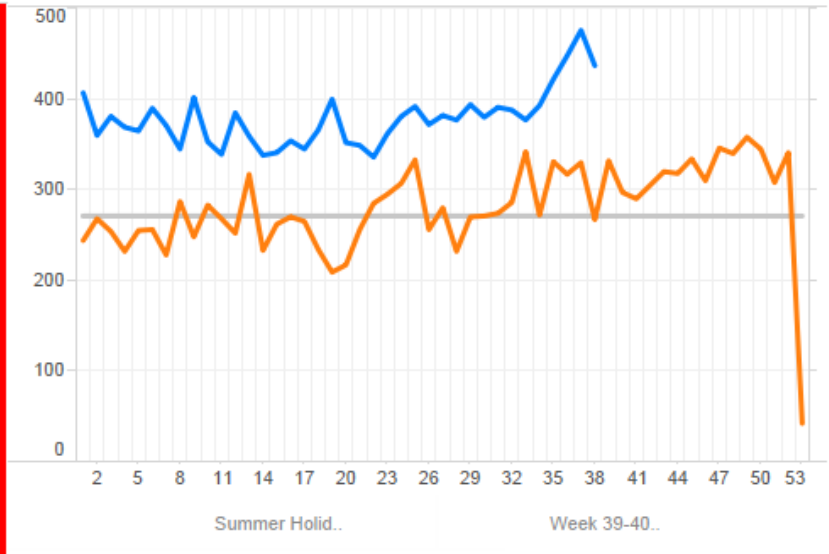
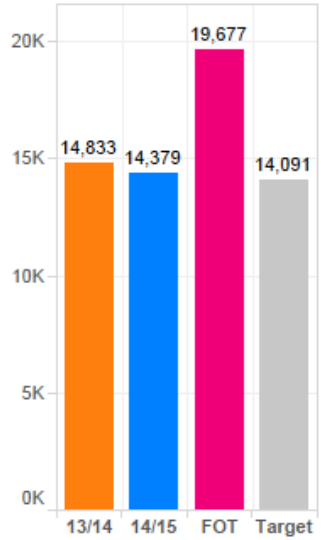
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	1,072	1,140	1,180	1,139	1,053	1,279	1,164	1,307	1,365	1,346	1,357	1,470	14,872
2014/15	1,632	1,628	1,566	1,544	1,591	1,601	1,714	1,685	1,418				14,379
Target	1,174	1,174	1,174	1,174	1,174	1,174	1,174	1,174	1,174				1,174
Variance by %	39.0	38.7	33.4	31.5	35.5	36.4	46.0	43.5	20.8				1,124.8

INFLOW

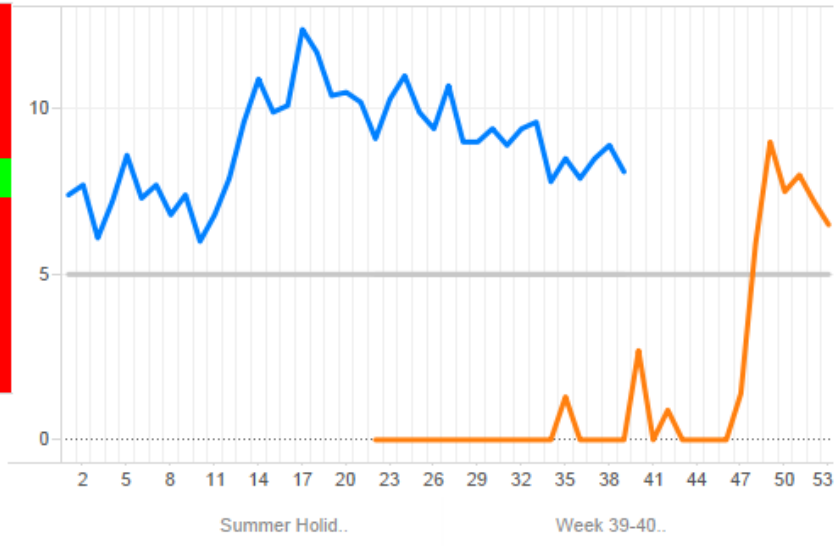
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

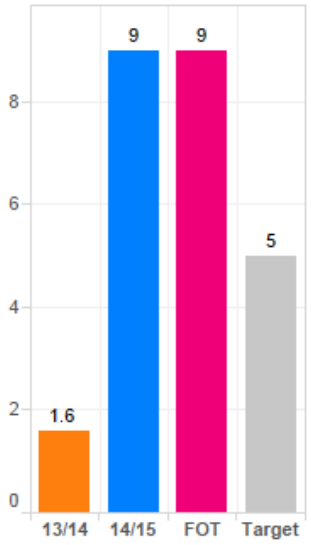
- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
EMAS Non Conveyance Rate by %	0	46	46	50	-8.0%
EMAS Turnaround: 15 Minutes or Less by %	49.4	46.1	46.1	50	-7.8%
UCC Conversion Rate to AE by %	27.4	36.4	36.4	32.8	11.0%
UCC Seen In 20 Mins by %	99.2	99.2	99.2	99	0.2%
UHL AE Attendances	136,422	100,695	134,260	128,640	4.4%
UHL AE Attendances 65+	32,580	24,796	33,061	30,951	6.8%
UHL AE Attendances after 18:00 65+ by %	5.5	5.9	5.9	5.2	13.5%
UHL AE Attendances after 18:00 by %	32.5	32.8	32.8	30.9	6.1%
UHL Avoidable EM	13,481	10,603	14,509	12,806	13.3%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14						0	0	0.5	0.9	0.2	1.4	7.4	1.6
2014/15	7.8	7.1	8.3	11.5	9.8	10.9	9.2	8.5	8.4				9
Target	5	5	5	5	5	5	5	5	5				5
Variance by %	56.0	42.0	66.0	130.0	96.0	118.0	84.0	70.0	68.0				80.0

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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- Discharge
- Emergency Department and Admission Units
- (•) Inflow

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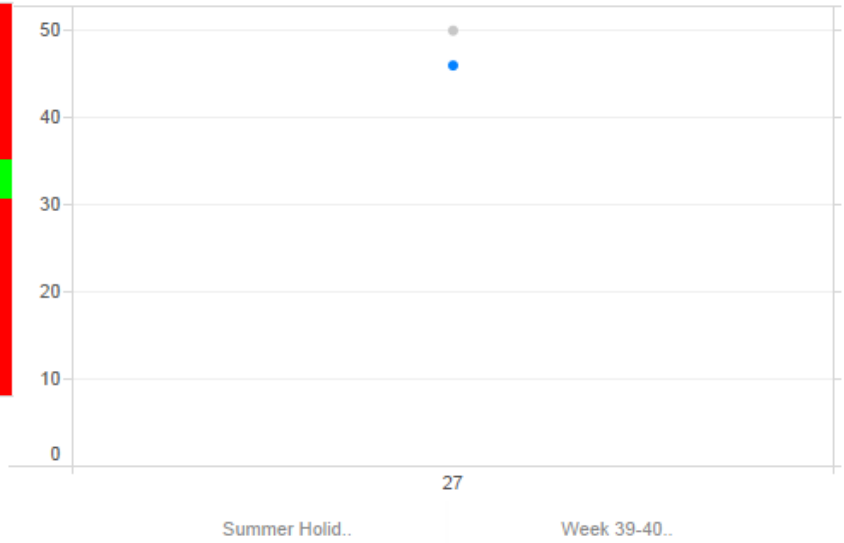
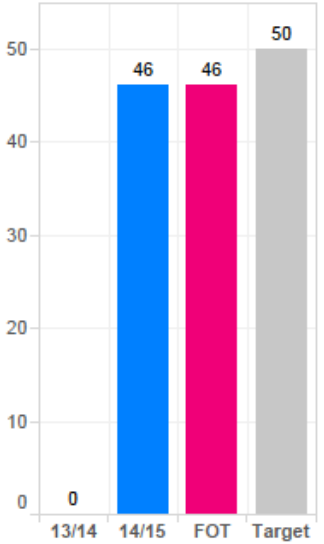


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Sep	
2014/15	46	46

Sep

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

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- ○ Discharge
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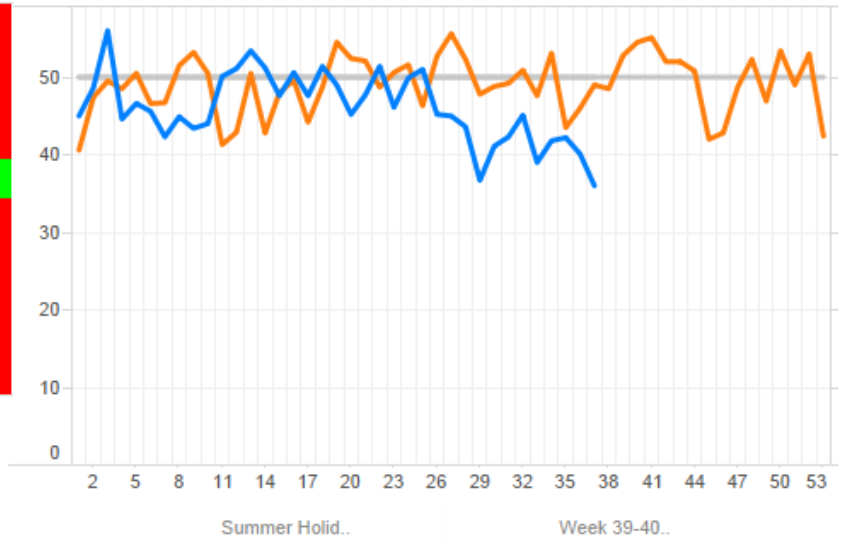
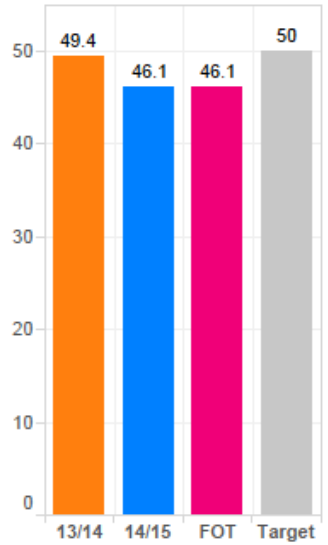
UHL AE Attendances 65+	32,580	24,796	33,061	30,951	6.8%
UHL AE Attendances after 18:00 65+ by %	5.5	5.9	5.9	5.2	13.5%
UHL AE Attendances after 18:00 by %	32.5	32.8	32.8	30.9	6.1%
UHL Avoidable EM	13,481	10,603	14,509	12,806	13.3%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	47.3	49.2	48.2	46.3	51.3	52.9	48.4	51	47.7	52.8	46.4	50.1	49.4
2014/15	47.6	44.7	48.5	50.5	49	46.4	42.2	42.6	38				46.1
Target	50	50	50	50	50	50	50	50	50				50
Variance by %	-4.8	-10.6	-3.0	1.0	-2.0	-7.2	-15.6	-14.8	-24.0				-7.8
	■	■	■	■	■	■	■	■	■				

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- (•) Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
EMAS Non Conveyance Rate by %	0	46	46	50	-8.0%
EMAS Turnaround: 15 Minutes or Less by %	49.4	46.1	46.1	50	-7.8%
UCC Conversion Rate to AE by %	27.4	36.4	36.4	32.8	11.0%
UCC Seen In 20 Mins by %	99.2	99.2	99.2	99	0.2%
UHL AE Attendances	136,422	100,695	134,260	128,640	4.4%
UHL AE Attendances 65+	32,580	24,796	33,061	30,951	6.8%
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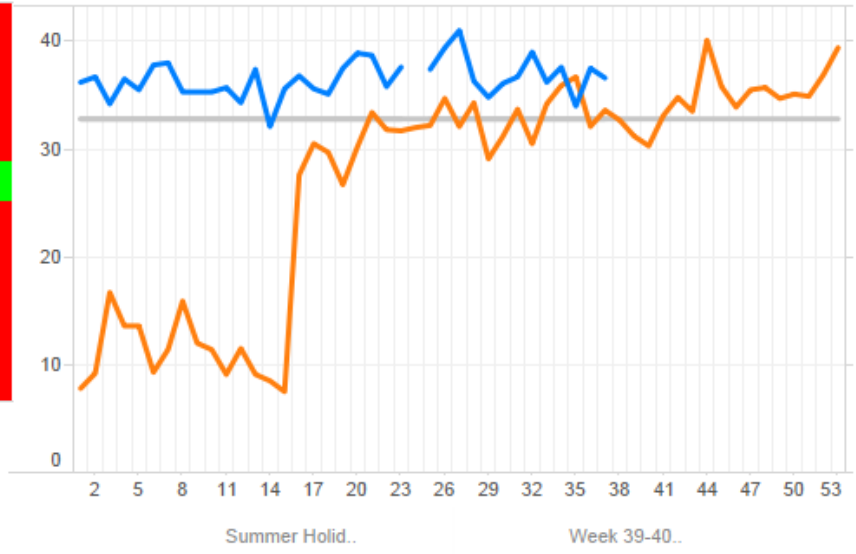
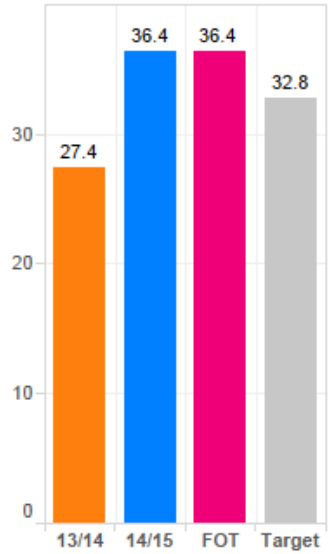
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	12.8	12.1	10.4	21.1	29.7	32.5	32.6	33.4	33	34.3	36.3	36.4	27.4
2014/15	35.4	36.2	35.5	35.2	37	39.2	37	36.4	37				36.4
Target	32.8	32.8	32.8	32.8	32.8	32.8	32.8	32.8	32.8				32.8
Variance by %	7.9	10.4	8.2	7.3	12.8	19.5	12.8	11.0	12.8				11.0

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
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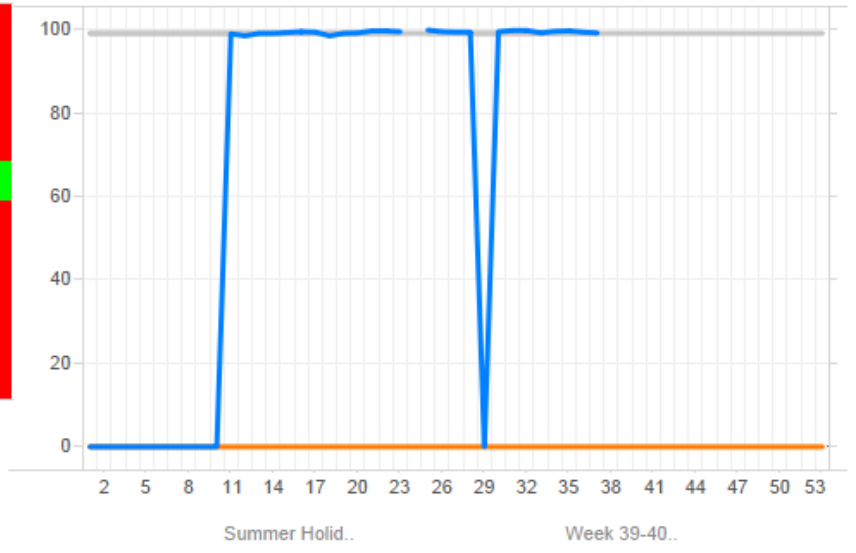
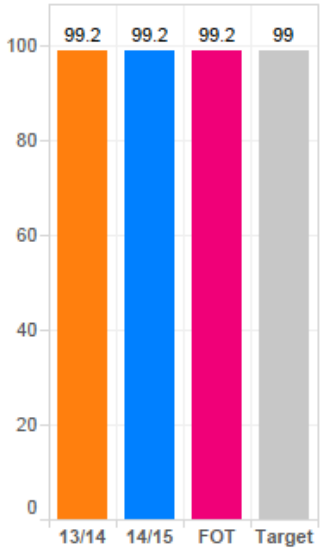
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	0	0	0	0	0	0	0	0	0	0	0	0	0
2014/15	0	0	65.9	99.2	98.9	99.5	79.5	99.6	99.2				68.5
Target	99	99	99	99	99	99	99	99	99				99
Variance by %	-100.0	-100.0	-33.4	0.2	-0.1	0.5	-19.7	0.6	0.2				-30.8

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance rom Target
111 disposition to ED by %	1.6	9	9	5	80.0%
EMAS Non Conveyance Rate by %	0	46	46	50	-8.0%
EMAS Turnaround: 15 Minutes or Less by %	49.4	46.1	46.1	50	-7.8%
UCC Conversion Rate to AE by %	27.4	36.4	36.4	32.8	11.0%
UCC Seen In 20 Mins by %	99.2	99.2	99.2	99	0.2%
UHL AE Attendances	136,422	100,695	134,260	128,640	4.4%
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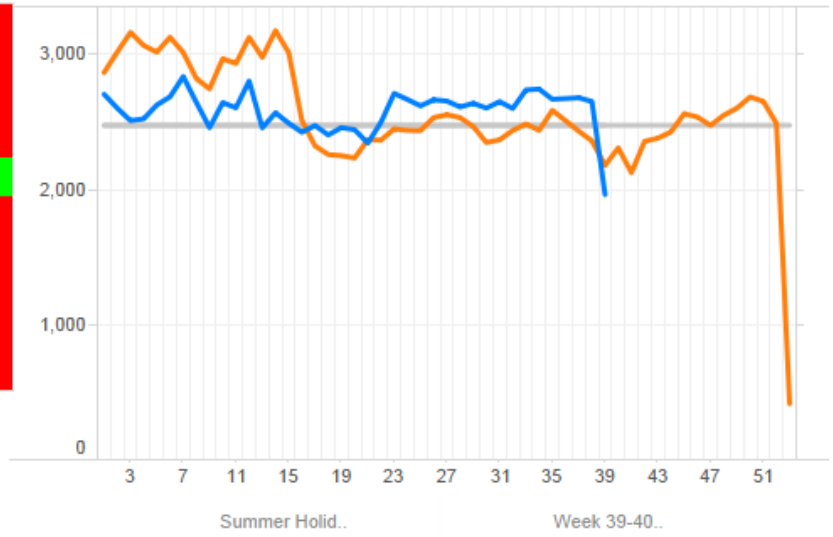
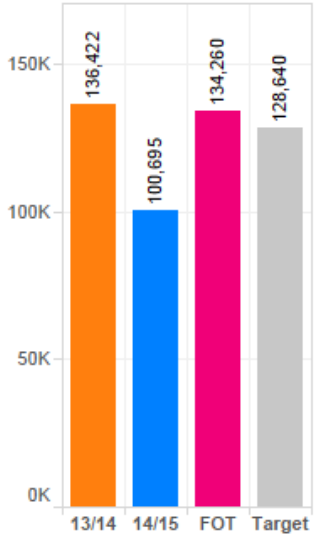
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	12,969	13,015	12,846	11,979	10,150	10,576	10,853	10,553	10,518	10,246	10,086	11,619	135,410
2014/15	11,011	11,779	11,295	10,940	10,791	11,381	11,643	11,471	10,384				100,695
Target	10,720	10,720	10,720	10,720	10,720	10,720	10,720	10,720	10,720				10,720
Variance by %	2.7	9.9	5.4	2.1	0.7	6.2	8.6	7.0	-3.1				839.3

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow (selected)

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
EMAS Non Conveyance Rate by %	0	46	46	50	-8.0%
EMAS Turnaround: 15 Minutes or Less by %	49.4	46.1	46.1	50	-7.8%
UCC Conversion Rate to AE by %	27.4	36.4	36.4	32.8	11.0%
UCC Seen In 20 Mins by %	99.2	99.2	99.2	99	0.2%
UHL AE Attendances	136,422	100,695	134,260	128,640	4.4%
UHL AE Attendances 65+	32,580	24,796	33,061	30,951	6.8%
UHL AE Attendances after 18:00 65+ by %	5.5	5.9	5.9	5.2	13.5%
UHL AE Attendances after 18:00 by %	32.5	32.8	32.8	30.9	6.1%
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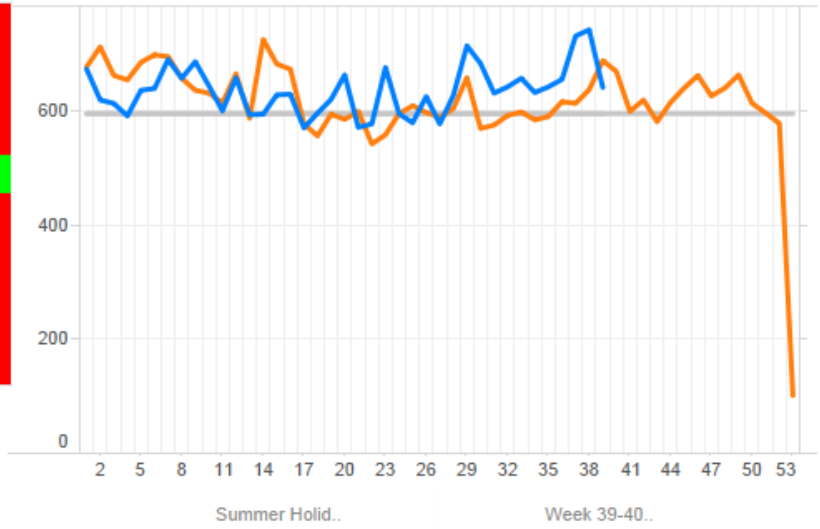
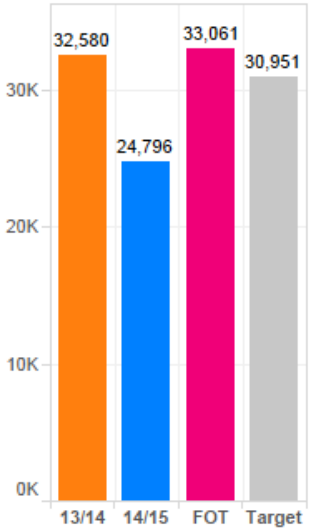
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	2,889	3,031	2,653	2,893	2,558	2,511	2,674	2,518	2,839	2,711	2,579	2,724	32,580
2014/15	2,671	2,909	2,719	2,669	2,724	2,602	2,895	2,740	2,867				24,796
Target	2,579	2,579	2,579	2,579	2,579	2,579	2,579	2,579	2,579				2,579
Variance by %	3.6	12.8	5.4	3.5	5.6	0.9	12.3	6.2	11.2				861.5

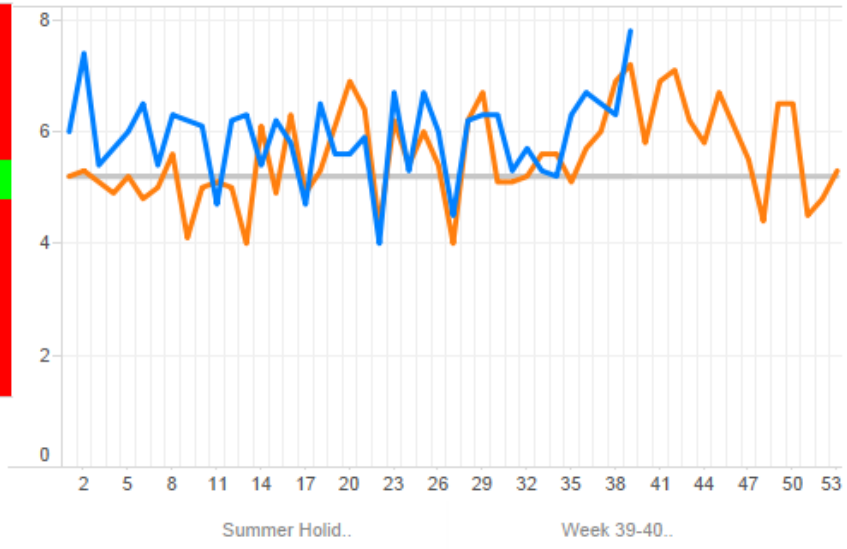
Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

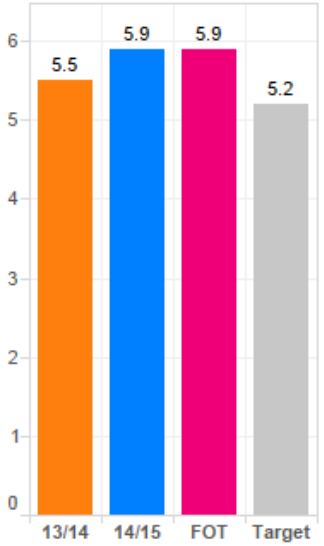
- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
EMAS Non Conveyance Rate by %	0	46	46	50	-8.0%
EMAS Turnaround: 15 Minutes or Less by %	49.4	46.1	46.1	50	-7.8%
UCC Conversion Rate to AE by %	27.4	36.4	36.4	32.8	11.0%
UCC Seen In 20 Mins by %	99.2	99.2	99.2	99	0.2%
UHL AE Attendances	136,422	100,695	134,260	128,640	4.4%
UHL AE Attendances 65+	32,580	24,796	33,061	30,951	6.8%
UHL AE Attendances after 18:00 65+ by %	5.5	5.9	5.9	5.2	13.5%
UHL AE Attendances after 18:00 by %	32.5	32.8	32.8	30.9	6.1%
UHL Avoidable EM	13,481	10,603	14,509	12,806	13.3%

Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	5.1	5.1	4.5	5.4	6	4.9	6	5.2	6	6.3	6.1	5.1	5.5
2014/15	6.3	6	5.8	5.7	5.8	5.3	5.9	5.3	6.8				5.9
Target	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2				5.2
Variance by %	21.2	15.4	11.5	9.6	11.5	1.9	13.5	1.9	30.8				13.5

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- ○ Base Wards
- ○ Discharge
- ○ Emergency Department and Admission Units
- ◉ Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
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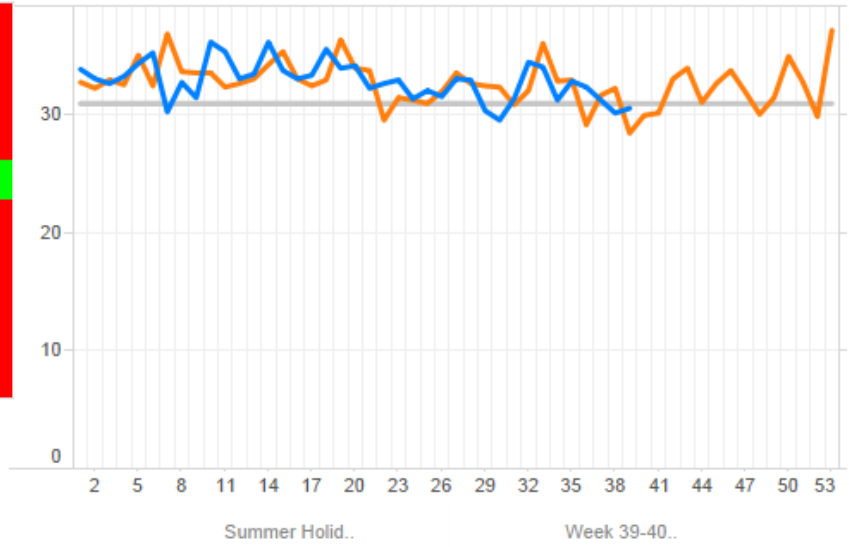
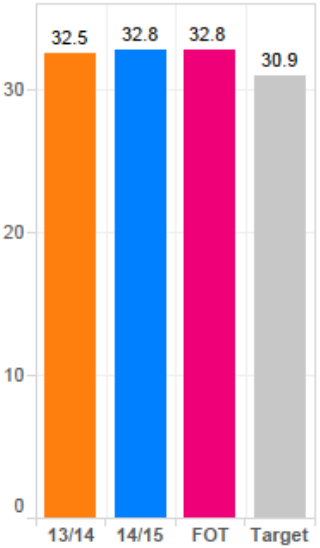
Weekly Trend against 2014/15 Target



Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	32.9	34.6	32.8	33.7	34	30.8	32.4	32.8	30.7	31.9	31.8	32.3	32.5
2014/15	33.7	32.7	33.6	34.8	33.1	32.1	32.2	32.2	31.3				32.8
Target	30.9	30.9	30.9	30.9	30.9	30.9	30.9	30.9	30.9				30.9
Variance by %	9.1	5.8	8.7	12.6	7.1	3.9	4.2	4.2	1.3				6.1

Urgent Care Weekly Dashboard

Week 38 - Run 29th December 2014

- Base Wards
- Discharge
- Emergency Department and Admission Units
- Inflow

	13/14	14/15	FOT	Target	Variance from Target
111 disposition to ED by %	1.6	9	9	5	80.0%
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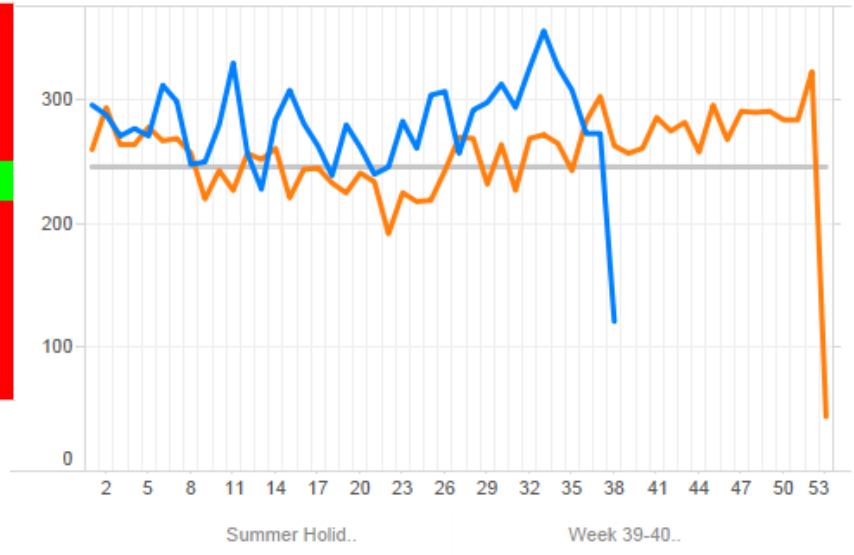
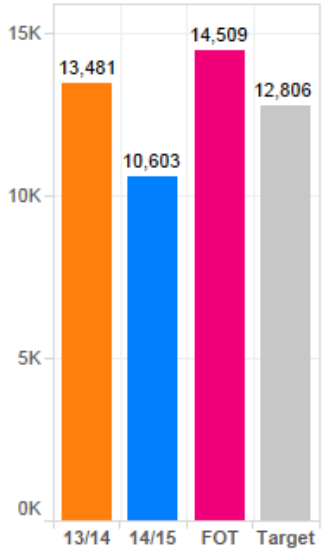


Annual Summary



Monthly Values and Variance against the 2014/15 Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
2013/14	1,172	1,168	1,012	1,079	1,003	962	1,137	1,113	1,216	1,230	1,133	1,278	13,503
2014/15	1,217	1,248	1,142	1,263	1,100	1,250	1,300	1,380	703				10,603
Target	1,067	1,067	1,067	1,067	1,067	1,067	1,067	1,067	1,067				1,067
Variance by %	14.1	17.0	7.0	18.4	3.1	17.2	21.8	29.3	-34.1				893.7

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper F

TRUST BOARD – 8 January 2015

One Year Operational Plan 2015/2016

DIRECTOR:	Kate Shields, Director of Strategy
AUTHOR:	Helen Seth, Head of Partnerships (Local services and BCT Lead)
DATE:	8th January, 2015
PURPOSE:	To present the first draft of the Trust's Operational Plan for 2015/2016 prior to submission to the NHS Trust Development Authority (NTDA) on the 13th January, 2015. Development of the planning documentation is an iterative process and it is therefore to be expected that the documents will be subject to change prior to final submission. The initial plan will consist of: • Narrative plan • 1 year high level Financial Plan (2015/16 plus 2014/15 forecast outturn) • 5 year high-level Capital Plan • Aggregate Activity Plan (Outturn 2014/15 and 2015/16) • 1 year Workforce Plan • Planning Checklists The planning checklists and detailed technical financial and workforce plans are in development (guidance published on the 19th December and circulated within the Trust on the 24th December). . These will be approved formally and made available subsequently to Board members following submission to the NTDA on the 13th January, 2015. There will be opportunity to discuss the first draft further and consider the risks identified in the narrative plan and cover paper at the 'Thinking Day' on the 15th January, 2015. The Trust Board is asked to **RECEIVE** the first draft of the Operational Plan for 2015.
PREVIOUSLY CONSIDERED BY:	Executive Team, 6th January, 2015
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [x] 4. Integrated care in partnership with others (secondary, specialised and tertiary care) [x] 5. Enhanced reputation in research, innovation and clinical education [x] 6. Delivering services through a caring, professional, passionate and valued workforce [x] 7. A clinically and financially sustainable NHS Foundation Trust [x] 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Engagement with stakeholders has been under the auspices of Better Care Together . From September 2014 the Trust along with other NHS and social care organisations has been working closely with the 'BCT Patient, Public, Involvement Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps), to ensure appropriate involvement and engagement.

Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Once the refreshed plan has been agreed an Equality Impact Assessment will be undertaken on the whole plan. In addition to this, an EIA is integral to each individual business case.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** **Board Assurance Framework** ☒ **Not Featured** ☐
ACTION REQUIRED * For decision ☐	For assurance ☒ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work* tick applicable box

First draft - One Year Operational Plan 2015/2016

PURPOSE

1. To present the first draft Operational Plan for 2015/2016.

2. The planning checklists and detailed technical financial and workforce plans are in development (guidance published on the 19th December and circulated within the Trust on the 24th December). These will set the detailed figures and metrics underpinning our financial, investment strategy and workforce initiatives.

BACKGROUND

3. On the 19th December 2014 the National Trust Development Authority (NTDA) published the operational planning guidance for 2015/2016. It confirmed the need for NHS Trust's to submit first draft operational plans by 13th January 2015.

4. This represents year 2 of our 5 year delivery plan which was approved by Trust Board in June 2014 and was refreshed and presented to Trust Board in December 2014.

5. All content has previously been through the Executive Team meetings, the Finance and Performance Committee and previous Trust Board meetings.

6. The content in the Operational Plan represents a point in time in this year's planning round.

AREAS OF NOTE FOR TRUST BOARD

7. The first draft Annual Operating Plan reflects all Trust Board discussions to date and includes the refocusing of our plans following the Trust Board's 'Thinking Day' in October, 2015.

8. The planning checklists and detailed technical finance and workforce plans are in development. These will be approved formally and made available subsequently to Board members following submission to the NTDA on the 13th January, 2015.

9. There will be opportunity to discuss the first draft further and consider the risks identified in the narrative plan and cover paper at the Trust Board 'Thinking Day' on the 15th January 2015.

10. There are areas of risk in our 2015/2016 plan that will need consideration at the 'Thinking Day'. These are:

    a) A bed reduction of 130 during 2015/2016 as patients no longer requiring acute care are transferred to a suitable, lower acuity setting ideally their home. This project will be delivered in partnership with Leicester Partnership Trust and other partners and will require clear objectives that are agreed and monitored by the

Trust Board. The scale and pace of this change represents a material risk which will need to be reflected on the corporate risk register.

b) Workforce reductions will need to be aligned to our transformational work through the Cost Improvement Programme Management Office. The Trust delivered 2% workforce reduction last year.

c) The potential impact of new tariff guidance for 2015/16 on financial planning assumptions. For example, the proposal that providers will receive 50% of tariff for specialised activity over baseline.

d) The potential impact of the national contract for 2015/16 on financial planning assumptions. For example the potential for up to 18 month lead time, prior to counting and coding changes being actioned.

RECOMMENDATION

11. The Trust Board is asked to receive the first draft of the Operational Plan for 2015/16.

Annex A: Summary of One Year Operational Plan 2015/16 (First draft – will be subject to change)

University Hospitals of Leicester NHS Trust

Strategic context and direction **To include:** Outline of plan delivery in 2014/15 and narrative on the progress anticipated in 2015/16, within the context of the Trust's previously submitted five year plan to 2018/19. To include the impact of strategic commissioning intentions, service changes, local health economy factors, competitive position, strategic developments, transactions and organisational sustainability.	**PLAN DELIVERY IN 2014/2015** **1.**Our two year operational plan was approved in April, 2014. It identified three cross cutting issues that the Trust would focus on in securing progress against our strategic objectives. We said we would: •*Effectively lead and manage service provision in line with defined standards whilst delivering our financial plan and improving productivity;* •*Build effective strategic partnerships to support delivery of safe and sustainable core and specialised services;* •*Prepare strong foundations for forthcoming, large scale transformation – including improvement activities at scale and pace and early enabling capital schemes;* **2.**During 2014/2015 our primary focus has been predominantly on the first item. As we look to 2015/2016 it is important to reflect on what has gone well and not so well. **QUALITY IMPROVEMENT – ACTING ON THE CARE QUALITY COMMISSION (CQC) REPORT** **3.**The Trust was visited by the CQC in January, 2014 and received the draft report in March, 2014. The overall rating for the acute services provided by the Trust was "requires improvement". As anticipated it highlighted some areas for improvement many of which already feature in our plans. Key headlines include: ○**SAFE -** The CQC rated University Hospitals Leicester (UHL) as requiring improvement in this area. To date, there has been an improvement in safety-related Key Performance Indicators (KPIs), with 12 out of 16 being amber or green RAG rated. Particularly good progress has been made on compliance with SEPSIS6 Care Bundle and the incidence of pressure ulcers within the Trust.

- **CQUIN -** Performance against CQUIN's has been exemplary in 2014/2015 with only 1 out of 60 Commissioning for Quality and Innovation (CQUIN) indicators being RAG rated red. This was due to an isolated Methicillin-resistant Staphylococcus Aureus (MRSA) bacteraemia which was retrospectively confirmed as unavoidable.

- **CARING -** The CQC rated the care provided at UHL as good in January, 2014. To date, 11 out of 13 KPIs for the caring domain for which targets have been agreed are RAG rated green or amber. Performance continues to be monitored and action plans are in place to address low outpatient friends and family test scores and single sex accommodation breeches.

- **EFFECTIVE -** Rated as good by the CQC, UHL continues to strive to provide effective care. This was confirmed by KPIs at the end of 2013/14, where 13 out of 14 were RAG rated amber or green. Importantly, the trust's SHMI remains within the expected range. The number of fractured Neck of Femurs (NOF) operated on between 0-35 hours from admission was lower than target in 2013/14 and continues to be a challenge.

- **RESPONSIVE -** The CQC rated UHL as requiring improvement in this area and it continues to be a significant challenge. To date, 9/25 'responsive' KPIs are RAG rated amber or green despite increasing demand. Sustained improvement in and achievement of the Emergency Department (ED) 95% target remains the most significant challenge for UHL and partners in the local health system. Poor performance and care in the Emergency Department (ED) and Clinical Decisions Unit (CDU) is symptomatic of wider system failure which is being compounded by further increases in emergency hospital admissions. This pattern is being replicated nationally.

4. Overall ED performance continues to be below target; Performance from 1/12/ 2014 to the 11/12/14 was 85.1%. Demand for emergency admissions (adult) has continued to steadily rise (circa 10% higher than the same period in November 2013). Delayed transfers of care have risen recently and are at 5.7% (every 1% equates to a ward).

5. Performance against the two week wait target, the 31 day wait for treatment, 31 day wait for second treatment, 62 day wait for first treatment (GP referral) and 62 day wait for first treatment (screening referral) are all below target in-year having previously reflected good performance; demand on the 2 week wait pathway has increased by 18% without impact on the incidence of cancer diagnosis. UHL, together with primary care are taking steps to manage the on-going daily pressure being experienced due to increased demand.

6. Referral to Treatment (RTT) –Throughout 2014/2015 the Trust has achieved significant RTT backlog reductions. This represents a major achievement. Performance is in line with agreed performance trajectory. Despite this improvement, a number of RTT specialities have seen an increase in GP referrals which has impacted on the ability of the speciality to

deliver RTT performance on a sustainable basis. Illustrative examples include gastroenterology and general surgery**.**

7.WELL LED - UHL was considered to be well-led by the CQC in January, 2014. Related KPIs show this continues to be the case. All but one of the 2013/14 KPIs were RAG rated amber or green. In 2014/2015 performance has improved further in a number of areas. Friends and Family Test coverage has increased to target levels; statutory and mandatory training completion rates are at 87% (compared to year end in 2013/14 of 76%) and is on target to hit our improvement trajectory at the end of March, 2015 (95%); 98% of staff have attended a corporate induction (against a target of 95%).

8.Progress against the Organisational Development Plan in 2014/2015 is going well. Illustrative examples include the introduction of an 'Organisational Health Dashboard' for key HR indicators; the involvement of the UHL Clinical Senate in developing medical leadership and the introduction of value based recruitment processes.

9.The Trust continues to facilitate Listening into Action (LiA) 'Pass it on' events. LiA is becoming 'the way we do things at UHL'. 'Nursing into Action' for wards is progressing well with a focus on listening events to improve the quality of care and patient experience.

2014/2015 COST IMPROVEMENT PROGRAMME (CIP) DELIVERY

10. The CIP programme for 2014/2015 is £45m – reflecting 5.3% of the cost base. The Trust has had the benefit of the support from Ernst & Young to enhance governance and support delivery. This will continue as we move in to 2015/2016.

11.A clear CIP identification, planning and monitoring framework has been implemented. This has evidenced a step change in performance in CIP delivery with the total value of schemes on the Programme Management Tracking Tool (PMTT) reaching £48.05m (£45.86m risk adjusted). For month 7 the total forecast value has increased slightly to £48.18m and importantly the value of green RAG rated schemes totalling £45.14m meeting the value of the CIP target for the first time. This represents a major achievement.

12. Robust cost control has been central to delivery of the financial plan underpinned by feasible mitigations including enhanced non-pay control, strengthened vacancy management, filling post substantively (reducing premium pay).

ALIGNMENT AND GOVERNANCE	13.A Department of Health Gateway Zero review of UHL's reconfiguration and transformation programme was carried out in October, 2014. It received an amber/red assessment. The primary purpose of a Department of Health Gateway zero review is to review the outcomes and objectives for a programme and confirm that they make the necessary contribution to wider local government, NHS and/or organisational overall strategy. For UHL this would be the Leicester, Leicestershire and Rutland (LLR) Better Care Together (BCT) programme. 14.Plans to reduce activity and reconfigure clinical services across LLR require a significant amount of work to deliver the required change. Current variation in demand above plan highlights the size of the challenge. 15.For the Trust, delivery of our plan is critically interdependent with delivery of the LLR BCT programme and the Local Authority Better Care Fund programme. Whilst the LLR BCT programme has a series of workstreams established to drive system change, UHL did not have a similar governance structure to oversee and coordinate the required activities. 16.To that end, an internal programme of work has been established to deliver the Trust's transformation and reconfiguration plans and effectively contribute towards the BCT vision. The governance framework aligns CIP plans and BCT reconfiguration activities through a number of enabling cross cutting workstreams (*see Appendix 1) with the major productivity projects focused on beds, outpatients, theatres and workforce. This provides the framework within which the Trust, Clinical Management Groups (CMG's) and specialties are developing their plans (to agreed milestones). Governance arrangements have been put in place to monitor progress and mitigate risks to delivery with Executive input and oversight. A Delivery Board has been set up as the mechanism to carry out this function and to align with the wider health economy BCT Programme.
PROGRESS ANTICIPATED IN 2015/2016	17.For the Trust, the focus in 2015/2016 will continue to be on realising internal efficiencies as well as working with partners to move prioritised activity to lower acuity, community settings. To do this we will need to build effective strategic partnerships to support delivery of safe and sustainable core and specialised services and build strong foundations for forthcoming, large scale transformation. 18.The Trust's published a five year "directional" plan in June, 2014. It is aligned to the LLR BCT programme, national planning guidance and policy direction. No sooner had this been approved when a number of key drivers for change emerged. There is no alteration in the direction of travel described in the Trust's Strategic Direction (November, 2012): "In five years' time we expect to be delivering better care to fewer patients, we will be significantly smaller, more specialised, and financially sustainable". There are however revisions to our planning assumptions driven by: •Anticipated requirements of clinical standards

•Publication of NHS England's Five Year Forward View (November, 2014) and the Dalton Review (December, 2014)

•The challenge from the National Trust Development Authority (NTDA) to go "further, faster" to reconfiguration

•Actions required in response to external reports

•Service sustainability: The need to consolidate ITU services on grounds of clinical safety;

19.A number of these will have an impact in 2015/2016 including:

•Progress in the delivery of the new **Emergency Floor** development (currently at Full Business Case). Phase 1 development will be operational in 2016/2017 and Phase 2 (assessment beds) in 2017/2018. The **consolidation of vascular services** with the move of **vascular surgery** from the Leicester Royal Infirmary (LRI) to Glenfield Hospital (GH) (currently at OBC and will be operational in 2016/2017). * rephased capital plan see Appendix 2

•**Single Children's Hospital –** The work programme to establish a single Children's Hospital will be initiated in 2015/2016 starting with the development of an Outline Business Case (OBC). It is anticipated that the OBC will be approved in September 2015.

•**Strategic Partnerships** -The Trust has carefully considered the best operational model that will help the service rise to the challenge of the forthcoming clinical standards for congenital heart services. Throughout 2015/2016 the Trust will explore the establishment of a strategic alliance with Birmingham Children's Hospital which could provide a collaborative model of delivery, governance, research and development and is in line with some of the opportunities outlined in the Dalton Review.

•**Maternity Business Case –** Due to the critical interdependency between Women's and Children's services the business case to consolidate maternity services will be brought forward and will be initiated in late 2014/2015. The OBC will be developed in 2015/2016.

•**Intensive Therapy Unity (ITU) Consolidation -** The Trust has established a discrete cross-cutting workstream to support the relocation of ITU (and interdependent services) from Leicester General Hospital by December, 2015. This will be supported by a two stage estate solution (interim and long term). In order to accommodate re-provision to the LRI, a significant estate footprint will need to be released. This will be facilitated by acceleration in the transfer of patients who no longer require acute care and bringing

	•**Treatment Centre -** The plans for this development have been brought forward with work starting in 2015/2016 (part new build/part refurbishment). Outline Business Case approval in forecast to be in August 2015 and FBC approval in February 2016. This together with an increase in planned activity delivered through the LLR Planned Care Alliance in Leicestershire community hospitals should have significant impact on the sustainable achievement of the Referral to Treatment Time (RTT) standard. •**Accelerated out of hospital community care** (for patients no longer requiring acute intervention)- As part of the Trust and BCT plan, LLR partners have agreed to work together to support the early transfer of patients who no longer require acute care, ideally back to their home. Based on the need to release estate footprint to relocate LGH ITU and the challenge to go "further, faster" the Trust is working with LPT to deliver this change over the next two years starting with a shift in 130 beds worth of activity to non-bedded alternatives in the community. This aligns to the planning assumptions underpinning the BCT programme and commissioning intentions to secure a step change in out of hospital care and improvements in the care of the frail older person. **COST IMPROVEMENT PROGRAMME (CIP) 2015/2016** 20.The Trust is planning to secure £41m in CIP savings for 2015/2016. 21.The CIP Programme is managed by the CIP Programme Management Office on behalf of the Trust with performance reported monthly to the Finance and Performance Committee and the executive team. 22.Four cross cutting workstreams are planned to coordinate activities in areas that affect more than one CMG. These will be: Beds Utilisation, Theatres, Outpatients and Workforce. 23.Currently £30.7m has been identified in total towards the £41m, equating to 75%. 44.21% of this is currently RAG rated amber/green. 24.Finalisation of CIP plans is incorporated into the business planning process with the expectation that plans will be in place for 80% of the CIP target (£32.8m) by 31 January, 2015 and 100% by 30 March, 2015.

Approach taken to improve quality and safety **To include:** The approach to quality improvement, the methodology used and the key improvements to be delivered over the next year across the five CQC domains of quality: safe, caring, effective, responsive and well-led. Consistent with information contained within the Trust's published Quality Account.	25. The Trust's 'Quality Commitment' aims to define UHL's approach to quality improvement and reflects the largely positive findings of the recent CQC inspection completed in January 2014. 26. The Trust has robust governance structures, processes and controls in place to promote safety and excellence in patient care; identify, prioritise and manage risk arising from clinical care; ensure the effective and efficient use of resources through evidence-based clinical practice; and protect the health and safety of patients, public and Trust employees. 27. Each clinical service sets annual quality priorities aligned to 14 strategic quality goals agreed across UHL. The Board sets annual quality priorities for the Trust, drawing these from locally set priorities and incorporating national standards, CQUIN requirements, patient and stakeholder feedback, from contracts. The agreed priorities form a framework for CMG and service level quality priorities and reflect specific patient needs. These are developed through discussion with clinicians, including nursing and medical staff taking into account incidents, risks, complaints and feedback. **DELIVERING THE ACTIONS RESULTING FROM THE LLR QUALITY REVIEW AND THE STURGESS REPORT** - 28. Published in July 2014, the LLR Quality Review was jointly commissioned by UHL, LPT and the three local CCGs in response to a consistently high SHMI in 2012/13 and early 2013/14. The aim of the review was to identify areas where care quality delivered across the healthcare system could be improved. According to the reviewers 23.4% of cases received care of an unacceptable standard and 54.6% of cases received care where lessons could be learned. 29. Where lessons can be learned and issues are identified these have been integrated into the Trust's quality action plans for the current and forthcoming year. 30. One of the most significant issues identified was a lack of joined up healthcare provision locally. To overcome this, and with the aim of addressing historic cultural issues both within and between healthcare organisations in LLR, a Task Force has been established. The Task Force is chaired by the Chairman of West Leicestershire CCG, (also a practicing GP locally), and the group has constant executive-level representation from each healthcare organisation involved in the review. Meetings are also attended by Healthwatch and Local Medical Council. 31. In addition to the Quality Review, Dr Ian Sturgess, an expert in emergency care pathways, was commissioned by LLR partners to provide recommendations on how the emergency pathway can improve. His report published in November, 2014 found that the local system is 'relatively fragmented with barriers to effective integrated working'. 32. A recommendation was made to focus on the following issues:

	•**Admission avoidance** – ensuring people receive care in the setting best suited to their needs rather than the Emergency Department. This fits with the work programme of the Better Care Together programme more specifically the Urgent Care, Long Term Condition and Frail Older Person workstreams. •**Preventative care** – putting more emphasis on helping people to stay well with particular support to those with known long-term conditions or complex needs. This fits with the work programme of the Better Care Together programme and CCG specific proactive care strategies. •**Improving internal processes** within UHL •**Discharge processes** across whole system - ensuring there are simple discharge pathways with swift and efficient transfers of care. •The action plans that respond to both reviews and the governance structure to support change have now been integrate within the BCT programme structure, thereby placing quality at the centre of all we do.
Delivery of operational performance standards Including contractual and national targets and standards.	33.The Trust will continue to work with partners across LLR through the BCT to improve operational performance standards in the short, medium and long term. 34.UHL will continue to make improvements to its internal process through the service review process, the CIP programme and the four cross cutting workstreams. Examples include greater management and clinical input on wards at weekends, the opening of additional capacity on the LRI site and focussing on earlier ward rounds across all three sites. 35.LLR partners are putting a lot of effort into improving the discharge process with greater numbers of external partners in-reaching into UHL to support earlier transfer of care when patients no longer require acute care.
Workforce plans Including proposed changes, quality impact, staff engagement and support.	36.A workforce Plan for 2015/2016 is being completed by each CMG as part of the on-going business planning process which incorporates baseline establishment; growth schemes and cost improvement programmes. The output of this process will provide granular detail of the changing workforce. Key to delivery will be staff engagement and support through Listening in to Action (LiA); analysis of staff feedback (survey / friends & family) and consultation with staff / staff side.

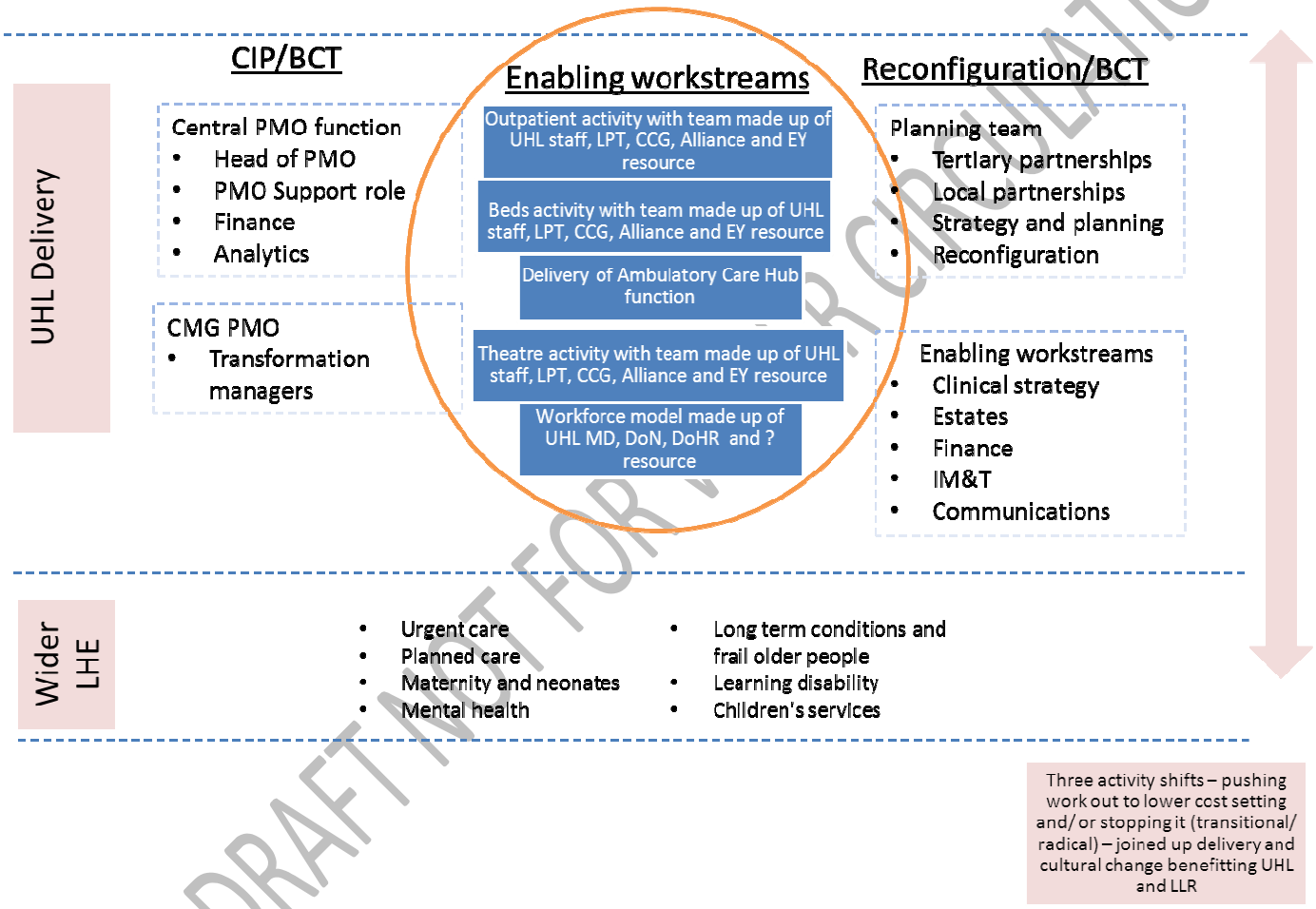
Financial and investment strategy **To include:** One year financial plan, financial sustainability, cost improvement programme, QIPP/BCF, capital and key risks and risk mitigation.	37. The Trust is currently working through an iterative planning process with CMGs and corporate directorates. As a result the initial financial and workforce plan submissions will reflect this current stage of planning and be subject to change prior to the final submission on 30th March 2014. 38. The Trust's financial plan for 2015/2016 is a planned deficit of £36.1m which is consistent with year 2 of our 5 year financial plan and assumes the following: •Tariff deflation and cost inflation are as per tariff guidance (1.9% each) •Increased capital charges and borrowing costs as a result of planned capital spend and loans to support the deficit and capital programme. •No assumed contractual benefits from contract terms or counting and coding agreements. 39. Further work is underway to validate each of these assumptions, with the impact of tariff being key. Discussions with CMGs and directorates have been taking place to support development of the income plan and develop a clear understanding of the minimum income required to service expenditure plans 40. The Trust has a robust strategy to deliver efficiency savings with the support of an expert external consultancy to help embed the governance and PMO processes. In 2015/2016 the programme will focus predominantly on 4 cross cutting work streams: bed utilisation, theatres, outpatients and workforce. The financial plan assumes the delivery of £41m in CIP savings and identification of these savings is on track within the iterative planning process described above.
Longer term financial sustainability, income, costs, activity, capital and risk mitigation.	41. The Trust's five year "directional" plan published in June 2014 included a Long Term Financial Model (LTFM) which reflected implied efficiency rates and realistic assumptions in respect of income, patient activity, inflation and staffing levels. This plan was in line with the BCT plan in the local health economy. 42. Since then the Trust has worked closely with BCT partners to ensure the growth, modernisation and transformation of services is consistent with the Trust's own strategy and reflected in the LTFM. As an active partner in the BCT programme, the Trust has contributed towards the development of a LLR Financial Model which is being adopted by all partners across the health economy. This reflects the planning assumptions within the Trust's LTFM.

Plans to improve efficiency and productivity through the more effective use of information and technology.	43.The Trust is investing in information technology at an operational and strategic level to support improvement in efficiency and productivity. 44.At a strategic level, the Trust has selected its preferred partner for an Electronic Patient Record (EPR). This will move in to implementation in 2015/2016. 45.At an operational level the Trust has purchased QlikSense which facilitates the monitoring, analysis and presentation of information to support:- Patient Outcomes & Safety, Patient Experience, Clinical Staff Resourcing, Quality Schedule and CQUIN indicators, Performance Management and Financial Management. It will empower UHL staff to make better and more efficient use of data and information across multiple domains. Benefits include the rapid development of Emergency Care Data Pack for immediate use and real time clinical coding to help drive improvements in capturing all co-morbidities. 46.The Trust also has access to a range of benchmarking tools including CHKS and Healthcare Evaluation Data (HED). Both are on-line tools which help the Trust identify clinical and productivity efficiencies comparing UHL performance with other NHS Trusts.
Organisational relationships and capability **To include:** Patient and public engagement, relationships with stakeholders and leadership development.	47.From the publication of our Strategic Direction in November 2012, which set out the case for smaller, more specialised hospitals and the transfer of more services to the community, engagement with key stakeholders has been constant and consistent. Clearly the UHL 5 year strategy is set within the wider context of the LLR BCT programme and logically therefore the engagement with stakeholders has been under the auspices of BCT. From September 2014 the Trust along with other NHS and social care organisations has been working closely with the 'BCT PPI Forum' (a lay body of local stakeholders from the likes of Healthwatch, Patient Public Groups, 3rd sector, media reps), to ensure that involvement and engagement is hardwired into the developing BCT plans and to co-create the approach to wider public engagement and consultation post the May election. The first drafts of these plans will be discussed by the BCT Partnership Board and the Patient and Public Involvement (PPI) Group in late January, 2015.
Development priorities and actions that the Trust is taking to meet its development needs.	48.The Trust has developed and submitted a detailed development plan to the TDA in November, 2014. The key headlines can be summarised as follows: **Priority 1: Trust Board development- embedding Board disciplines** **Action –** Secure resources for coaching and training to produce shorter reports, informed by analysis and identifying key issues to be addressed **Priority 2: Clinical leadership**

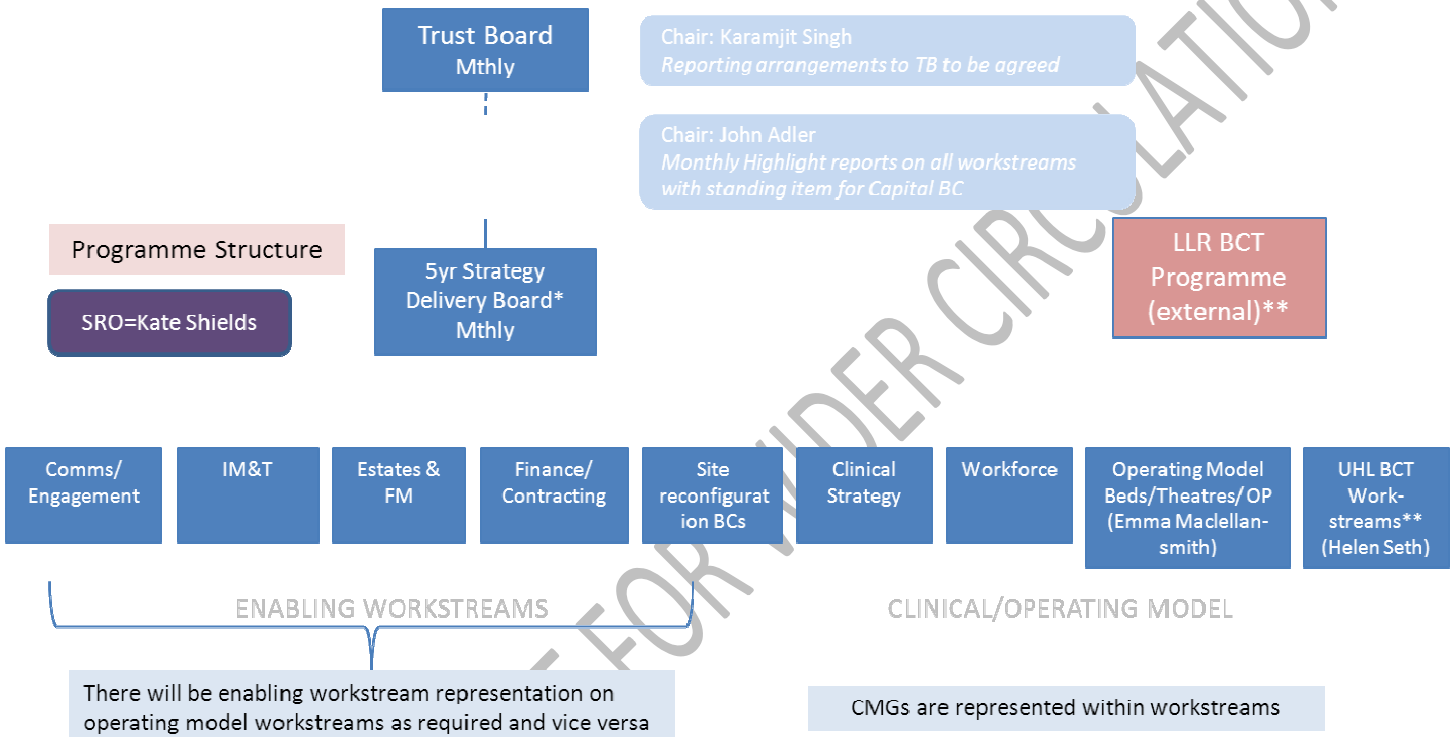
	Action - Work with NHS Improving Quality (NHS IQ) and the Leadership academy to systematically develop structures and processes for developing and garnering clinical leadership; set out clear expectations and sanctions as part of job planning and annual appraisal; train appraisers; clinical senate established; establish a similar model for nursing and midwifery **Priority 3: Culture and behaviours in teams** **Action -** Develop a programme brief that describes the scope of change planned, the anticipated benefits and outcomes of the 5-year plan and aligns this to the strategic priorities and values of the organisation; thorough engagement with staff to establish ownership of the plan; use the LiA methodology to provide clarity of roles and responsibilities (for all staff) to deliver the 5 year plan; coaching and development of the Executive Team and continue Practice Crucial Conversation Sessions (across CMG) in partnership with Momentum; building on-the ground change capacity with the support of NHS IQ Support **Priority 4: Patient & Public involvement** Action - More time and resource invested in to CMGs to free up staff time to engage within the Trust and in the wider community; seek support and guidance from NHS England, in developing a PPI strategy that will seek to strengthen our PPI within the Trust as well as linking into the wider community; Link into the Patient and Public Voice Team at NHS England; access to medical leaders in other health economies who are prepared to coach/enthuse support our CMG leadership teams. **Priority 5: Financial sustainability** **Action -** Enabling resource has been implemented for CIP which includes CMG specific support and also a number of cross cutting themes, each led by an Executive Director. This will be further refined in 15/16 to focus on four main areas (Beds, Outpatients, theatres and workforce) ; a five year internal CIP plan has been drafted and is currently in consultation with senior leader; external work-streams via BCT to support financial sustainability, service and pathway change. Requirement to provide an umbrella view and hold the interdependent areas (including organisations) to account to deliver the whole; externally the BCT programme SOC will outline the system requirement for transitional funding and capital and cash resources to successfully deliver system and organisational reconfiguration **Priority 6: Improvement & Innovation methodology** **Action -** Agree a methodology and agree the deployment across UHL; develop communications plan that aligns improvement and innovation with the overall programme management arrangements for delivering the 5-year plan

APPENDIX 1

CIP and BCT Alignment



Governance structure for delivering the UHL five year strategy



All workstreams will have their own governance structure with PIDs, regular implementation meetings, and fortnightly highlights reports

***Delivery Board run by the Strategy PMO:**
SRO – Kate Shields
Clinical Lead - Deputy Medical/Nursing Directors
Finance Lead – Paul Traynor/ Paul Gowdridge
Programme Director – Ellie Wilkes
Programme Manager – Serina Koral

BCT Workstreams**

- Urgent care
- Planned care
- Maternity and neonates
- Mental health
- End of Life
- Children's services
- Long term conditions and frail older people
- Learning disability

APPENDIX 2

Estates Strategy 5 Year Phasing - "Further Faster" Dec 2014 Ver1.1

	2014/15 £k	2015/16 £k	2016/17 £k	2017/18 £k	2018/19 £k	TOTAL £k	*Total Dec-14*	OBC Start	OBC Internal	OBC Submission	OBC Approved	FBC Internal	FBC Submission	FBC Approved
Emergency floor LRI	13,000	25,000	10,000	-	-	48,000			Jul-14	Aug-14	Dec-14	Jan-15	Jan-15	Mar-15
Vascular GH	2,500	8,000	2,000	-	-	12,500			Jul-14	Aug-14	Jan-15	May-15	May-15	Jun-15
OPDC hub	3,000	20,000	32,000	3,000	-	58,000		Jan-15	Jun-15	Jul-15	Aug-15	Nov-15	Dec-15	Feb-16
Imaging GH	-	3,000	3,000	-	-	6,000								
Multi-story Car Park LRI	-	4,000	-	-	-	4,000								
Childrens' cardiac	-	3,500	-	-	-	3,500								
Childrens' IP/OP LRI	-	-	3,000	4,000	9,000	16,000		Jan-15	Jun-15	Jul-15	Sep-15	Mar-16	Apr-16	Jun-16
Outpatients LRI	-	-	-	3,000	2,000	5,000								
Inpatients LRI	1,500	2,000	8,000	10,000	2,000	23,500								
Theatres LRI	3,000	4,000	4,000	4,000	-	15,000								
Pathology GH	-	-	-	3,000	-	3,000								
Inpatients GH	-	6,000	9,000	15,000	-	30,000								
ITU LRI	500	-	-	14,000	2,000	16,500		Oct-15	Mar-16	Apr-16	Jun-16	Dec-16	Jan-17	Mar-17
Maternity LRI	400	7,500	27,000	31,000	-	65,900		Jan-15	Apr-15	Jul-15	Aug-14	Jan-16	Feb-16	Mar-16
LGH	1,000	-	4,000	4,000	-	9,000								
Entrance LRI	-	-	-	2,000	10,000	12,000								
Capital reconfiguration projects	24,900	83,000	102,000	93,000	25,000	327,900								

	14/15	15/16	16/17	17/18	
Maternity LRI	Feasibility and business case	Business case and Enabling works and demolition	New Build	New Build and refurb	Note uplift for out of sequence and possible disfunctional use

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper G

TRUST BOARD – 8 JANUARY 2015

UHL Mutuals in Health Pathfinder Update Report

DIRECTOR:	John Adler, Chief Executive
AUTHOR:	Bina Kotecha, Assistant Director of Learning and Organisational Development
DATE:	8 January 2015
PURPOSE:	**(concise description of the purpose, including any recommendations)** This report updates the Trust Board on progress with taking forward the Mutuals in Health Pathfinder Programme. This is a key element of delivery within the Organisational Development Plan under the 'Improving Two-Way Engagement and Empower our People' work stream.
PREVIOUSLY CONSIDERED BY:	N/A
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	Patient representative involvement ensured in all key development activity
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	Programme elements have been assessed against the nine protected characteristics under the Equality Act 2010.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☐ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

* tick applicable box

Cabinet Office

Mutuals in Health Pathfinder

Listening into Action

Department of Health

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Trust Board**

REPORT FROM: John Adler, Chief Executive

Report By: Bina Kotecha, Assistant Director of Learning and OD

DATE: 8 January 2015

SUBJECT: **Mutuals in Health Pathfinder Programme Update**

Purpose

UHL has been selected as Mutuals in Health Pathfinder and this report sets out key progress including:-

- Background to the pioneering Mutuals in Health Pathfinder Programme;
- A summary of UHL pathfinder programme elements;
- Details of the pathfinder programme outputs and the nominated national Programme Advisory Panel;
- Progress with the procurement of UHL's Support Contract (maximum contract value £120,000);
- Other support that will be provided as part of the pathfinder programme; and
- An outline of key next steps.

1. Background

In October 2013, Norman Lamb and Francis Maude asked Professor Chris Ham, Chief Executive of the King's Fund, and a panel of experts including UHL's Chief Executive to carry out an independent review of options for strengthening NHS employee's engagement in their organisations.

The review began in October 2013 and was published by the King's Fund at an event on 15th July 2014. The launch event was attended by Care and Support Minister Norman Lamb, Minister for the Cabinet Office, Francis Maude and Hazel Blears MP.

The objective of the review was to identify options for empowering staff to deliver better care via mechanisms such as improved working practices through to potential alternative provider models.

The review found compelling evidence that NHS organisations with high levels of staff engagement, where staff are strongly committed to their work and involved in decision-making, deliver better quality care. These organisations report:

- lower mortality rates
- better patient experience
- lower rates of sickness absence and staff turnover

Organisations with low levels of staff engagement are more likely to provide poor-quality care, the failures in care at Mid Staffordshire NHS Foundation Trust are a high-profile example of this.

While staff engagement levels have increased across the NHS in recent years, the review found significant variations between organisations. The report calls on all NHS organisations to make staff engagement a key priority in order to improve care at a time of unprecedented financial and service pressures.

The review found emerging evidence that staff-led mutual can deliver higher levels of staff engagement. The Mutuals in Health Pathfinder Programme is a joint Cabinet Office and Department of Health initiative designed to help NHS organisations consider the potential advantages of the mutual model.

2. UHL Mutuals in Health Pathfinder

Participation in the Pathfinder Programme will enable UHL to understand what mutualisation could mean for us, the potential benefits and issues and to identify solutions to practical barriers. The scope and vision of our mutual pathfinder proposal comprises 3 main elements:-

1. Explore the whole Trust mutual
    a. develop a business case i.e. “this is how it can be done here”
2. Autonomous, incentivised teams
    a. develop the framework and rules of engagement
    b. work with pilot teams to get them up and running
3. Embed staff engagement and a sense of ownership
    a. research best practice
    b. develop plans to further embed staff engagement in the Trust’s structure

In relation to element 1 above, the mutuals approach has not yet been tried in the acute sector, this is why the government has established the Pathfinder Programme. We would emphasise that this programme is intended to help further explore the potential and the issues involved and does not commit us to following any particular course i.e. no decisions to go down this route have been made.

There has been a great deal of interest in the pilot team work described in element 2 above. We confirm that at the initial phase, we will be working with Elective Orthopaedics and Orthopaedic Theatres and we will be exploring ways of getting them up and running as autonomous, incentivised teams.

We will continue to use Listening into Action to develop exemplary levels of staff engagement. We intend to continue to embed the voice of front-line staff in the structure of the organisation to "institutionalise" engagement and add to the sense of ownership and a shared agenda. There are variety of ways in which this could be pursued and we wish to develop these are part of the programme.

In progressing the pathfinder programme, we have established a UHL Mutuals in Health Pathfinder Programme Board with key stakeholder representation. The Board will be accountable to the Executive Team / Executive Workforce Board and report progress to key groups including Trust Board, JSCNC, LNC and the Patient Representative Group.

We have met with other selected pioneering pathfinder Trusts (9 in total as listed below) and shared with each other the specific details of each of our projects:-

- Cheshire and Wirral Partnership NHS Foundation Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Moorfields Eye Hospital NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Oxleas NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Tameside Hospital NHS Foundation Trust
- University Hospitals of Leicester NHS Trust

3. Pathfinder Programme Outputs and Programme Advisory Panel

A report will be produced by the nominated Programme Advisory Panel (representation as below), based on the conclusions and lessons learnt from the pathfinders and will make recommendations to the Government by May 2015.

Representative	Position
Chris Ham	CEO, Kings Fund
Rannia Leontaridi	Director of Transformation, Cabinet Office
Claire Stoneham	Deputy Director, Department of Health
Sir Charlie Mayfield	Chairman, John Lewis Partnership
Andrew Burnell	CEO, City Health Care Partnership
Jonathan Lewis	CEO, Bromley Healthcare
Bob Ricketts	Director of Commissioning Support Strategy and Market Development, NHS England
Craig Dearden-Phillips	CEO, Stepping Out
Ralph Coulbeck	Director of Strategy, NHS Trust Development Agency
Miranda Carter	Executive Director of Provider Appraisal, Monitor

The outcomes from this work is anticipated to feed into the Government's broader programme of work in 2015/16 to enable a range of new options for providers of NHS care, alongside recommendations resulting from the review being led by Sir David Dalton.

4. Procurement of UHL Support Contract

As part of the programme, we will be provided with bespoke technical, legal and consultancy support and our contract value has been agreed at £120,000 in meeting our support requirements to successfully deliver the three main elements of the programme as detailed in section 2 of this report.

As part of a central procurement process led by Crown Commercial Services, we received 8 bids from suppliers and bids have been evaluated by a panel of three evaluators with UHL representation. The process followed has been highly professional and robust. Each contractor has evaluated bids against 3 questions with pre-set criteria:-

- Support requirements (detailed feasibility and outline business case)
- Team structure
- Knowledge capture requirements (Final Project Report)
- Each contractor is also scored on pricing / added value in terms of number of days support provided

Based on the consensus scores the highest scoring supplier was Hempsons. In particular they scored higher on Team Structure which makes up 50% of the total marks i.e. breadth and depth of team in relation to Mutuals and NHS experience including suitability, relevant project experience and previous similar experience. The delivery team will comprise of legal advisers from Hempsons, mutual specialists from Stepping Out and Albion Care Alliance CIC.

The 'Intention to Award' letters for the Mutuals in Health Pathfinder Programme have been issued. Hempsons bid across a number of pathfinders however we were their number one preferred Trust. As they scored particularly strongly in all sections of their bid we are confident that we will be working with a strong team who understand the needs of our Trust. For reference Hempsons will also be partnering with Norfolk and Norwich University Hospital Foundation NHS Trust.

5. Other Support

Workshops

Workshops will be held on a monthly basis from January to March (at a national level), lasting about three hours. They are an important opportunity for the Programme Advisory Panel, Pathfinder Trusts, suppliers, mentors/buddies, and external experts where relevant to come together and discuss emergent findings. The workshops will enable Pathfinders to seek expert advice on specific issues as well as provide an opportunity for networking with attendees and exchange ideas.

Workshop 1: 20th January at 2pm -5:30pm
Workshop 2: 17th February 9:30am - 1:00pm
Workshop 3: 19th March 1:30pm - 5pm

The first two workshops will address specific issues that Pathfinders are working through. These could include questions around property and assets, access to finance, or regulatory systems. The last workshop will focus on drawing together the findings of all the Pathfinders. Looking at the 9 detailed reports from each Pathfinder and in discussion, this

session will focus on drawing out the shared themes and issues from across all the Trusts, in particular:

- Benefits of the chosen model;
- Key challenges faced, including remedial actions identified at a local level;
- Risks in moving to implementation and any national policy barriers; and
- How to ensure wider dissemination of the lessons learnt.

The Programme Advisory Panel will, based on the conclusions and lessons learnt from the 9 successful projects and the 3 workshops, put forward its over-arching findings on the key barriers identified and make recommendations to Government (through an internal report). Conclusions and lessons learnt from the 9 successful projects will be made available to the Advisory Panel by 31 March 2015.

Allocation of Mentor / Buddy
A mentor, or buddy, will be assigned to each Pathfinder. Following agreement as to which mentor is initially assigned to each Pathfinder, we will make contact to agree how to work together over the next three months.

6. Next Steps

The contract notices have been awarded on the 11th December, and we are currently in a ten day stand still period when suppliers can challenge Crown Commercial Services' decision. The contracts are expected to be awarded before the end of December 2014.

Contracts will commence with a kick off meeting on 5th January 2015, following which there will then be a three month intensive period of work which will conclude by 31 March 2015. We have made contact with the overall project lead appointed by Hempsons, in setting out the agenda and information requirements in preparation for the kick off meeting. We are working on producing a top ten list of knowledge transfer elements for sharing with the contractor during the initial meeting.

We will consider ways of partnering with Norfolk and Norwich University Hospitals NHS Foundation Trust given we are working with the same contractor.

7. Recommendations

The Trust Board is asked to note progress with taking forward the Mutuals in Health Pathfinder Programme. This is a key element of delivery within the Organisational Development Plan under the 'Improving Two-Way Engagement and Empower our People' work stream.

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper H

TRUST BOARD – 8 JANUARY 2015

The Annual Workforce Monitoring Report 2013-2014

DIRECTOR:	Emma Stevens , Acting Director of Human Resources
AUTHOR:	Deb Baker, Equality Manager
DATE:	8th January 2015
PURPOSE:	• To present the 2013-2014 Annual Workforce Equality Monitoring report; • To secure agreement to publish the above report on the UHL Web site in line with Public Sector Equality Duty; • To update on progress against the 2013-2014 equality workforce work programme; • To inform the Board of forthcoming changes to our monitoring arrangements, and • To agree the priorities for the 2015-2016 equality workforce programme.
PREVIOUSLY CONSIDERED BY:	The Executive Workforce Board 23rd December 2014
Objective(s) to which issue relates *	☐ 1. Safe, high quality, patient-centred healthcare ☐ 2. An effective, joined up emergency care system ☐ 3. Responsive services which people choose to use (secondary, specialised and tertiary care) ☐ 4. Integrated care in partnership with others (secondary, specialised and tertiary care) ☐ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☐ 7. A clinically and financially sustainable NHS Foundation Trust ☐ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	The Annual Workforce Equality Monitoring Report once agreed will be published on the internal and external web site. The report will also be shared with the Equality Advisory Group our external reference group.
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	The workforce equality updates and monitoring reports are produced, to firstly provide us with the data we need to be able to evidence whether we are a fair and inclusive organisation. Secondly the information highlights areas where further development work or changes to processes may be required and informs the overall equality work programme for the coming year.
Organisational Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☐ **Board Assurance Framework** ☑ **Not Featured**
ACTION REQUIRED *	

For decision	√	For assurance	√	For information	

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **8th JANUARY 2015**

REPORT BY: **DEB BAKER, SERVICE EQUALITY MANAGER**
EMMA STEVENS, ACTING DIRECTOR OF HUMAN RESOURCES

SUBJECT: **EQUALITY WORKFORCE PROGRESS REPORT**

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1. BACKGROUND

1.1 In July 2014 the Equality Annual Report was presented to the Trust Board. This detailed both the patient and workforce elements of the Equality Work Programme which is determined by the NHS Equality Delivery System (EDS). The EDS helps NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010.

2. INTRODUCTION

2.1 This paper specifically outlines our compliance with the Public Sector Equality Duty (PSED) where we are required, in relation to workforce, to :-

- Eliminate unlawful discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups which are:-

Race/ethnicity, Sex, Religion or belief, Gender Reassignment, Sexual orientation including lesbian, gay and transsexual people, Age, Marriage and Civil Partnership, Disability - learning disabilities, physical disability, sensory impairment and mental health problems

2.2 Following endorsement from the Trust Board, UHL will publish (by the 31st January 2015) the Annual Workforce Equality Monitoring Report which is a statutory requirement.

3 THE PURPOSE OF THE PAPER

3.1 This paper details:

- National Workforce Equality requirements.
- Progress against the workforce elements of the 2013 -2014 equality work programme.
- This year's Equality Workforce Monitoring Report (at **Appendix 1**).
- Priorities for 2015-2016 (at **Appendix 2**).

4. EQUALITY COMPLIANCE 2013 – 2014

4.1 We produce an annual employee profile as a way of monitoring that our workforce broadly reflects the diversity of the community we serve and to ensure that our

practices are free from discrimination. We are required as part of the Public Sector Equality Duty to publish this data that includes equality analysis on:-

- Our overall workforce profile.
- Pay differences.
- Recruitment.
- Number of staff leaving.
- Number of Disciplinary and Grievance cases.
- Access to training.

4.2 As a result of the findings, an annual equality work programme is produced and monitored using the Equality Delivery System (EDS) framework.

4.3 We are required to have at least one workforce objective for each of the two domains (a representative workforce and that we have an inclusive approach to Leadership) .We therefore need to be able to demonstrate that all of our workforce processes, policies and procedures are fair, open to all and free from discrimination. Progress against the work programme for the EDS is outlined in section 5.

5 WORKFORCE EQUALITY METRICS

5.1 An important area of national focus for this year has been Black and Minority, Ethnic (BME) career progression and representation. New research reported in the Roger Kline report entitled the ''Snowy White Peaks'' found that the absence of Black and Minority Ethnic (BME) NHS staff from the leadership of the NHS is ''serious, systemic and has shown no sign of improving in recent years''.The seemingly slow progress has culminated in a pledge from NHS England to implement the two following measures to improve equality within the workforce across the NHS, which would start in April 2015:-

5.1.1 Race Equality Standard

The first is a workforce race equality standard that would, for the first time, require organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation. In addition it is proposed that this may form part of the NHS 2015-2016 contract. In terms of the new standard some of the information required is already collected and /or reported. The new activity will be the more regular validation of Trust Board member details and the details of responses to the staff survey questions by BME group. However, the bigger challenge for us and others will be what new or additional strategies are there that will bring about an effective shift from our current position.

Workforce Metric	UHL's Current Position
Percentage of BME staff in Bands 8-9 and VSM compared with the percentage of BME staff in the overall workforce**.**	Already collected and reported in the annual Workforce Report. Section 3.2.

Relative likelihood of BME staff being recruited from short listing compared to that of white staff being recruited from short listing across all posts.	Already collected and reported in the annual Workforce Report. Section 3.3.
Relative likelihood of BME staff entering the formal disciplinary process, compared to that of white staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	Already collected and reported in the annual workforce Report. Section 3.7.
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? If so were any training, learning or development needs identified?	Question within the National Staff Survey and will request breakdown of answers by BME group in 2015.
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? If so Were any training, learning or development needs identified? Did your manager support you to receive this training learning and development?	Question within the National Staff Survey and will request breakdown of answers by BME group in 2015.
Percentage believing that trust provides equal opportunities for career progression or promotion.	Question within the National Staff Survey and will request breakdown of answers by BME group in 2015.
In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	Question within the National Staff Survey and will request breakdown of answers by BME group in 2015.
Does the Board meet the requirement on Board membership (Boards are expected to be broadly representative of the population they serve.)	The Board members details were last validated in June 2014. The Board is under represented in terms of Ethnicity, Women and Disability.

5.1.2 **The Equality Delivery System**

The second measure is to make the use of the EDS mandatory. The regulators – The Care Quality Commission, Trust Development Agency and Monitor – will also

consider using the standard to help assess whether organisations are 'well-led. UHL already uses the EDS 2 framework so work will continue to progress the standards.

A self assessment of the EDS is undertaken annually and validated by our Equality Advisory Group. In addition to this, for this year we want to trial in collaboration with the City Clinical Commissioning Group and Leicestershire Partnership Trust a broader stakeholder validation event. This is scheduled for February and March 2015.

6. PROGRESS AGAINST THE WORKFORCE 2013-2014 WORK PROGRAMME

We identified a range of work streams following the publication of last year's report; the highlights of which are described below.

6.1 Band 7 Representation

It has become evident through the publication of our data that there has only been minimal change year on year in terms of BME representation at senior levels (at bands 8a and above). As described in section 4 this is a national issue and one that requires on-going attention.

Our focus last year was to narrow our scope to one professional group rather than looking at all senior posts. We selected Nursing as we had in previous years looked at the level of BME nurse recruits at De Montfort University (DMU). We hoped to see an increasing trend in band 7 appointments for BME staff that corresponded to the increasing number of BME student nurses recruited by DMU since we first started monitoring in 2007.

The positive news is that we have seen an increase in BME band 7 appointments and that this upward trend within Nursing is continuing. By analysing the data in this way we are able to see some improvement thereby reassuring us that by taking a more long term view the progression of BME staff through the bands is evident albeit slower than we would like.

That said we do need to ensure that there is equal opportunity for all staff across the organisation and that we need to develop some targeted interventions that better support staff development generally but particularly BME staff.

We already know that from this year's report that BME staff appear to be under represented on all training courses which includes leadership /management courses. In conjunction with the Learning and Organisational Development team there are 3 areas of focus where we have the opportunity to proactively support the development of BME Staff. The first is regarding our talent management strategy and links to a series of Talent Management Master Classes that are being run from March 2015. Secondly, whilst we have a mentoring system within the Trust the uptake is variable and less well accessed by some staff groups and possibly BME Staff. It is also likely that a renewed national interest BME specific Leadership /mentoring courses may be reintroduced by the Leadership Academy. The third area to consider and explore is introducing the concept of unconscious bias into our recruitment and equality training.

6.2 Data Collection and Analysis Through Benchmarking within the East Midlands

The Regional Equality Leads meet quarterly and share data. Similar trends have been identified across the Region with no areas identified as outlying for UHL.

6.3 Dyslexia Guidance for Staff

An increasing number of staff are identifying themselves as Dyslexic or Dyscalculic and require in the main educational support. Dyslexia falls under the Equality Act 2010 and as a result we have developed guidance for managers on reasonable adjustments in terms of job role and examinations/professional testing.

6.4 Dyslexia Assessment Training

In addition to the guidance we have trained eight members of staff to undertake dyslexia screening assessments to enable earlier intervention, unnecessary formal testing and cost savings.

7. EQUALITY TRAINING

Progress against the 3 yearly Mandatory Equality training is positive and remains on course against UHL's predicted trajectory – currently 75%.

8. 2013- 2014 WORKFORCE MONITORING REPORT - POINTS OF INTEREST

The attached equality workforce monitoring report (see appendix 1) is produced as part of our compliance with the Public Sector Equality Duty. The key highlights of the report include:

- The total staff head count remains comparatively stable with minimal changes in the equality profile across the organisation. We have continued to see an improvement in the quality of staff data, resulting in an increase in the number of areas we can report on.

- We are pleased to report more evidence of promotion/ appointment of staff from BME background, female staff and staff identifying as LGB into more senior roles. The deep dive work undertaken does provide reassurance that representation is changing but that progress is slower than we would want.

- Overall applicants from a white background continue to fair better throughout the application process.

- There has, however, been a percentage reduction in the appointment of staff with a disability and those who are Atheist, which has not previously been seen, despite application levels remaining consistent.

- Working patterns of staff is a new area of reporting. We know 51% of our workforce work less than full time hours and the data shows that this is opportunity is accessed across the board by all groups. From examining the data in more detail there is evidence that more female staff, those from a white

background, those aged >60yrs, staff identifying as heterosexual and those who follow the Christian faith work part-time hours.

- The groups of staff involved in a disciplinary process have changed this year. We have seen higher representation amongst male staff, staff from a BME background and those from older age groups which were not evident last year, whilst representation of staff identifying as LGB have fallen. This has highlighted that trends will change year on year and it is only by consistently monitoring over several years that true trends will emerge. Staff declaring disabilities do, however, continue to be over represented. Further analysis of the data is required before any conclusions can be drawn and interventions developed.

9. THE AGEING WORKFORCE

9.1 We know that there is a particular issue in relation to Midwives that has previously been reported and detailed in the Women's and Children's workforce plan. The 5 year workforce plan acknowledges that there may be other staff groups for example Healthcare Scientists and Consultants that may be affected by a larger numbers of retirements than previously seen. It is important that as a Trust we have robust retirement plans in place. To this end a task and finish group will be established in the New Year to ensure that adequate plans are in or can be put into place.

10. PRIORITIES FOR 2015- 2016

10.1 The priorities for 2015-16 that are included in the EDS Workforce Programme are outlined in appendix 2.

11. SUMMARY

11.1 UHL continues to declare legal compliance with the Public Sector Equality Duty and has a range of activities and processes to evidence our position.

11.2 The total head count of staff remains comparatively stable with minimal changes in the equality profile across the organisation. We have continued to see an improvement in staff monitoring data, resulting in an increase in the number of areas we can report on.

11.3 Comparing the data to previous years it is evident that each year we see slightly different trends between groups and in different areas; however there are also key areas we are seeing year on year. This includes the challenge of representation at senior level. This in turn maybe linked to the under representation of some groups within our leadership programmes which will be a focus for next year.

11.4 The challenge for any organisation wanting to ensure it is fair will be to produce a best fit for the majority of staff while at the same time still meeting individual needs. In order to achieve this continuing to identify areas that would benefit from further analysis to provide a deeper understanding is essential.

12 RECOMMENDATION

12.1 The Trust Board is asked to note and agree the content of the Workforce Report and agree the priorities identified.

APPENDIX 1

Workforce Equality and Diversity

Monitoring Report 2013-2014

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

Contents

Executive Summary Equality Workforce Monitoring Report 2013-2014

1. Introduction

The Workforce monitoring report has been presented to the Trust Board as to comply with our Legal Duty we need to publish the data against the nine protected characteristics that are:

- Disability
- Sex
- Race
- Age
- Sexual Orientation
- Religion or Belief
- Marriage and Civil Partnerships
- Pregnancy and Maternity
- Gender Reassignment

Currently we collect and report staff data on disability, age, race, religion and belief, sex, and sexual orientation. We are still awaiting Government confirmation as to whether we will be expected to extend our data collection to all of the nine characteristics in the future.

In line with our requirements under the Public Sector Equality Duty we have collected, analysed and published our workforce data by:

- Overall workforce profile
- Pay
- Recruitment
- Staff leaving
- Working patterns
- Sickness
- Disciplinary and Grievance
- Training

Please note the analysis of Working patterns and Sickness are new to this years report.

2. Progress on Key actions identified in 2012-2013

Within each workforce report areas which would allow a richer understanding of some of the data are identified within our yearly action plan. Below is an update of how we are progressing:

We know that that like many similar organisations, representation at senior levels remains a challenge. The Equality and Diversity Council recently announced

'that more action was required to ensure that employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and fair treatment in the workplace.'

This year we have continued our work to drill deeper into the make up of our senior staff profile to understand what we may need to do diversify our representation at senior levels.

2.1 To conduct some further analysis for those BME staff appointed into band 7 positions.

It has become evident that there is often only minimal changes year on year of representation at senior level. One reason for this which was evident when we investigated the career aspirations of our band 6 staff was the availability of senior positions suggesting a lower turnover combined with fewer job roles. We therefore widened our scope to look at the longer term trends in BME appointment through bands 5 – 7 from 2007, 2010, and 2013 within our largest staff group, nursing and midwifery. The results clearly demonstrated a more defined percentage change in all bands every three years with an increase in BME at band 7 of 2.5 %, at band 6 of 5.5% and at band 5 of 3.4% between 2007 and 2013. This year's data at band 6 and 7 suggest this increasing trend is continuing, thereby reassuring us that by taking a more long term view the progression of BME staff through the bands is evident.

2.2 Investigate How Widely Flexible Working Options Are Accessed At Consultant Level.

An analysis of more detailed data was conducted which considered both the gender of consultants in each speciality and the working hours of consultants and the specialities they worked within. The analysis showed that 21% of consultants are working less that 1WTE, of these the male / female split was equal. A fairly even sex split was also seen amongst consultants working 1WTE. The largest proportions of consultants (57%) are working more that 1WTE and of these 80% are male.
When drilling down further into Speciality there are five services within the Trust that have no female consultants. The data has been shared with a newly emerged network championed within the Trust called Leicester Women in Medicine (LWIM) which hopes to motivate and support women in medicine at all levels of career to achieve their personal goals and realise their talent through peer support and mentoring.

3. Key Headlines As To How Our Data Has Changed.

- The total staff head count remains comparatively stable with minimal changes in the equality profile across the organisation. We have continued to see an improvement in the quality of staff data, resulting in an increase in the number of areas we can report on.
- In addition the numbers of declarations within disability, sexual orientation and religion and belief, has again increased by around seven percent. The numbers, however, still remain low in comparison to gender, age and ethnicity so we would like to see the figures rise more quickly than they are.
- Year on year we continue to see the challenge of representation at senior level. We are pleased to report more evidence of promotion/ appointment of staff from BME background, female staff and staff identifying as LGB into more senior roles which has changed the overall profile at senior level. The deep dive work undertaken does provide reassurance that representation is changing but that progress is slower than we would want.

- We continue to recruit across the Trust into a variety of job roles. Overall applicants from a white background continue to fair better throughout the application process.

- This years' data does demonstrate there is now significantly less difference in all groups between the percentage of applicants shortlisted and those then appointed.

- There has however been a percentage reduction in the appointment of staff with a disability and those who are Atheist, which has not previously been seen, despite application levels remaining consistent.

- Staff from an Islamic or Christian faith have faired better through the process this year as have applicants aged between 30-39 years.

- The data around staff leaving the Trust last year was influenced by a large number of employee transfers to a private contractor. Therefore the reasons and characteristics in this year's data are not directly comparable.

- In this years data we see an overrepresentation of staff that are male, from an Asian or 'other' background and those aged last than 30 yrs. For all of these groups the majority are leaving due to 'End of fixed term contract' which includes training schemes and rotational posts.

- Working patterns of staff is a new area of reporting. We know 51% of our workforce work less than full time hours and the data shows that this is opportunity is accessed across the board by all groups. From examining the data in more detail there is evidence that more female staff, those from a white background, those aged >60yrs, staff identifying as heterosexual and those who follow the Christian faith work part-time hours.

- Sickness is a new area of reporting this year so we do not have previous data to compare with. The data suggests when compared to others within the particular characteristic group a higher percentage of staff declaring a disability, female staff, staff identifying as bisexual or lesbian, and those aged less than 35yrs have taken a period of sickness. It is too early to draw any conclusions and will need further refinement in terms of what analysis is required.

- The groups of staff involved in a disciplinary process have changed this year. We have seen higher representation amongst male staff, staff from a BME background and those from older age groups which were not evident last year, whilst representation of staff identifying as LGB have fallen. This has highlighted that trends will change year on year and it is only by consistently monitoring over several years will true trends emerge. Staff declaring disabilities do however continue to be over represented, with this year's percentage higher than last.

- Our reporting of training data although improving remains inconsistent added to which there are high numbers of 'unknowns'. This reduces the certainty of the conclusions we can draw from it. From the data we do have we can see that there is an under representation of staff declaring a disability, from a BME background or identifying as LGB accessing leadership/management courses or short taught day courses provided by the learning and organisational development team. Data from our apprenticeship programme is more robust and does demonstrate a good representation across all groups.

  It should be noted however that representation has be measured against the representation of the total workforce. In some areas of training only a percentage of our workforce maybe eligible to access the courses offered. Further work to establish these baseline figures needs to be undertaken.

Section 1 – Disability

1.1 Disability profile of staff in post at UHL

Year ending	March 2014	March 2013	% of change
No	63.3%	56.8%	+ 6.5%
Yes	1.7%**	1.4%**	+0.3
Choose not to declare	3.7%	5.8%	-2.1
Unknown	31.3%	36%	-4.7

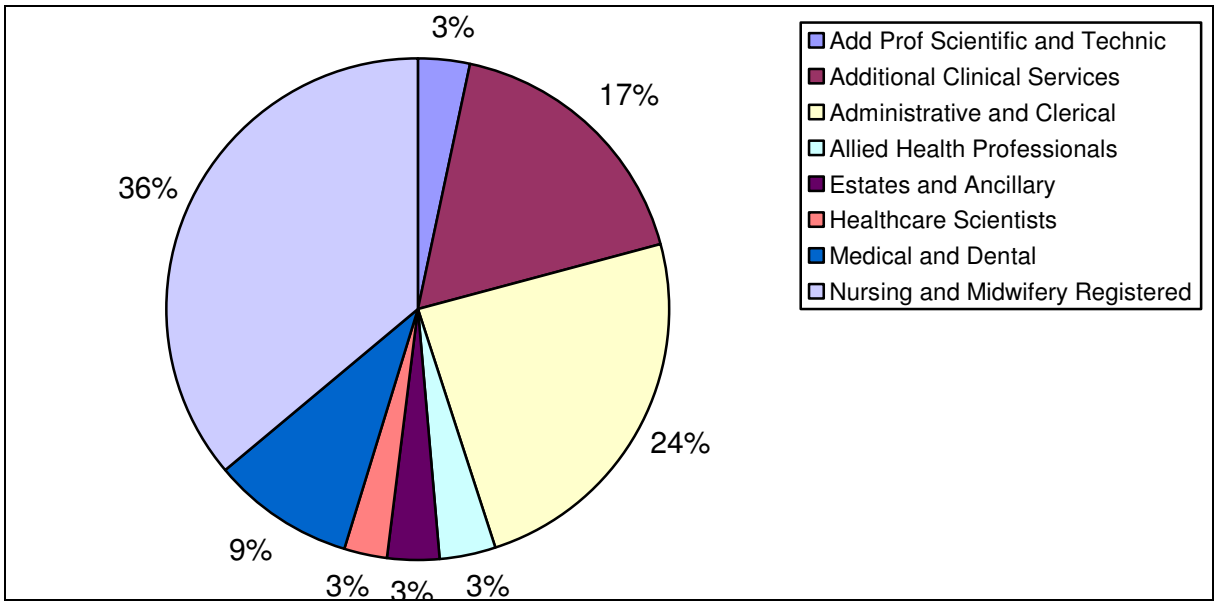
** 1.7%represents 206 staff members

Nationally 9.5% of working age people is defined as disabled under the Equality Act 2010. The Act defines an individual with a disability as having a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

Our data demonstrates that 1.7% of the workforce have declared a disability which is a slight increase from last year; however, a third of the workforce's disability status remains unknown.

In a recent staff survey of 3000 staff 579 (16%) declared that they had a long-standing illness, health problem or disability. This suggests a significant number of staff who may not declare themselves as having a disability would be supported under the Equality Acts (2010) definition of disability. For this reason the wording will be amended for our next ESR update to bring the definition in line with all national surveys.

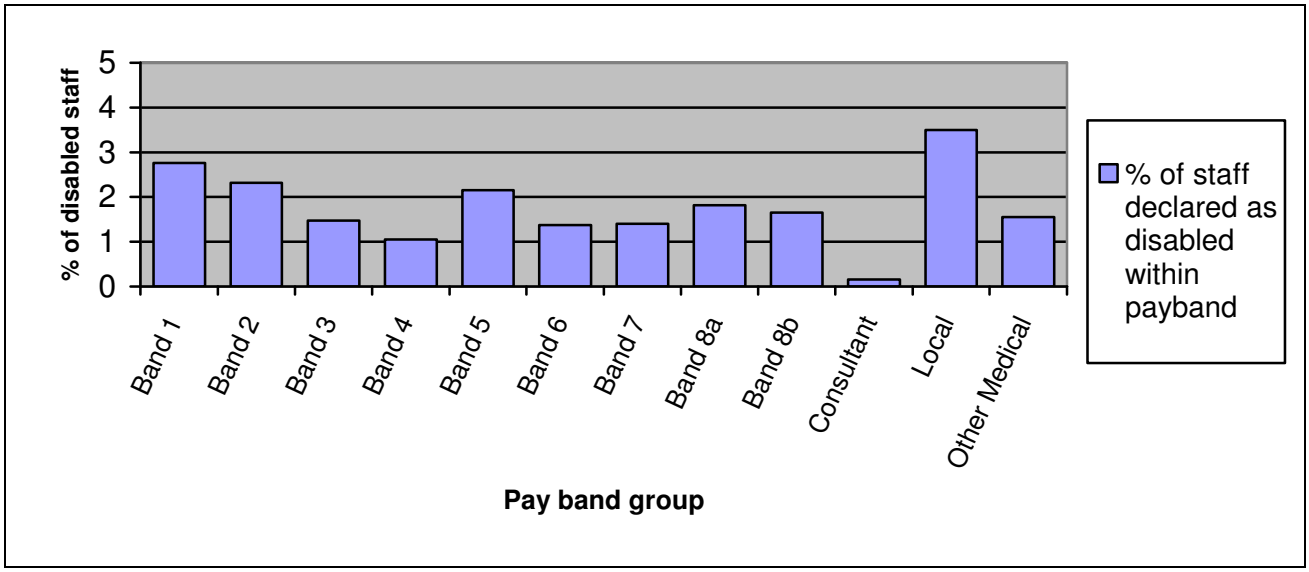
Comparison of the Percentage of disabled staff in each staff group.



The data demonstrates that all staff groups have seen an increase in the number of staff declaring a disability. This has altered the representation of disabled staff within some staff groups the most evident being:

- A decrease of 5% in administrative and clerical – in terms of head count there has been a slight increase and they remain over represented in relation to workforce numbers.
- An increase of 5% in nursing and midwifery – this group has seen the largest change in terms of headcount
- Medical and dental representation remains stable thereby they continue to be under represented in relation to their workforce numbers.

1.2 Disability and Pay

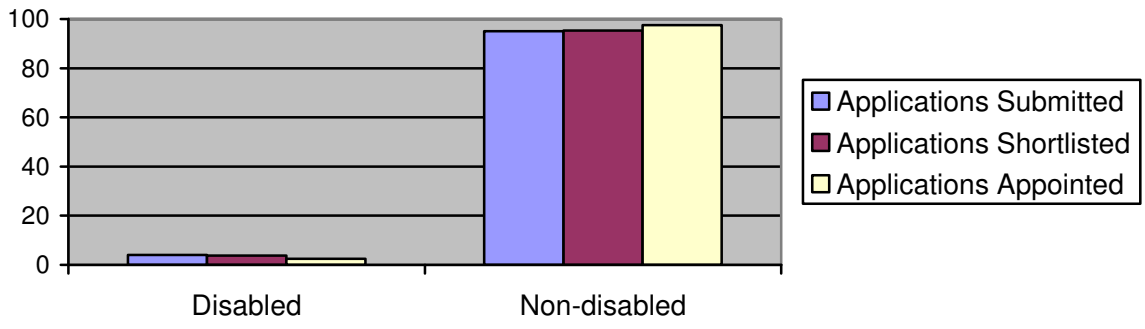


The data demonstrates that staff declaring a disability are represented at all bands except for 8C, 8D and band 9. When compared to last years data we see:

- An increase in representation in Bands 1,2,3,5,6, 8A, and other medical
- A decrease in representation in Bands 4, 7, 8B Consultant and local.

1.3 Disability Profile at Recruitment

Percentages of disabled and non-disabled applicants at each stage of recruitment process



The data demonstrates that:

- As seen in last years data less than 1% of applicants disability status is undisclosed.

- 98% of individuals appointment were non disabled compared to 95% seen in last years data.

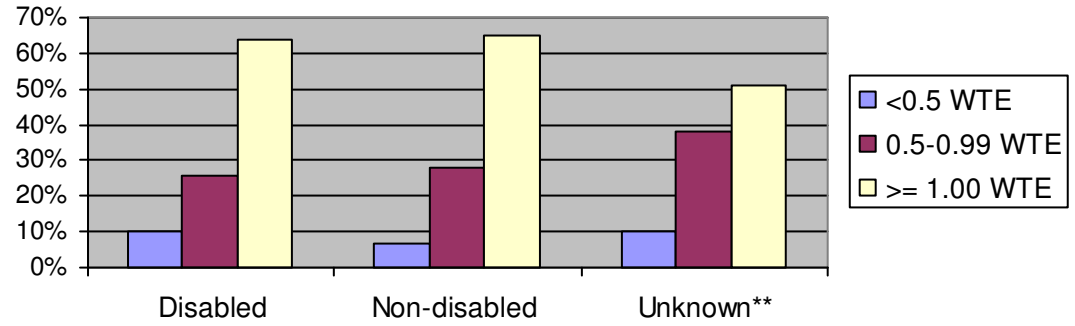
The percentage decrease of disabled staff at each stage of the recruitment process has not been seen in previous year's data.

1.4 Disability of Staff Leaving

Of staff that left the Trust 1.9% (32 staff members) defined themselves as having a disability. This figure is consistent with last year's representation.

1.5 Working Patterns

Percentages of working hours by disability status



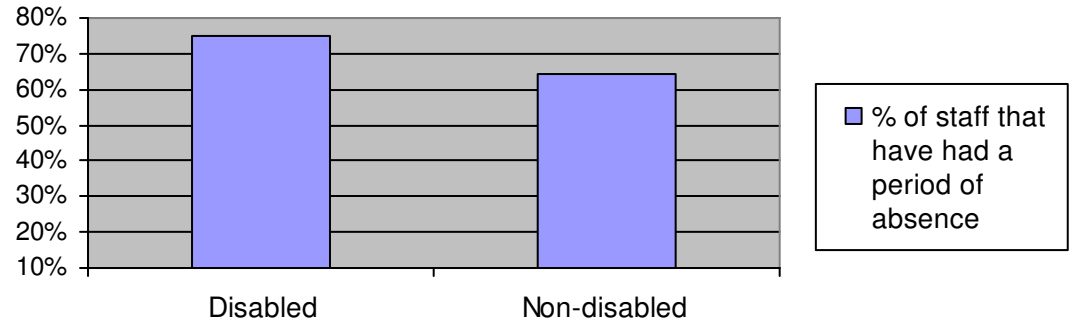
** In this instance unknown included both staff who does not wish to declare their disability status (11%) and those who have an undefined status (89%).

The data demonstrates that:

- A higher percentage of staff declaring a disability work <0.5 hours
- There is a minimal percentage difference between non-disabled staff and staff declaring a disability working full time hours.

1.6 Sickness and Absence

Percentages of staff absence by disability status



The data indicates the percentage of staff who has taken a period of sickness is higher in staff declaring a disability.

1.7 Disciplinary and Grievance Cases

A total number of 179 disciplinary processes and 12 Grievance cases were concluded during 2013-2014.

Disciplinary data by disability

	Disabled	Non-disabled	Unknown
Total %	3.91%	49.72%	46.37%

This year's data continues to suggest in relation to workforce representation a higher number of individuals who declare a disability have been involved in a disciplinary process.

Grievance data by disability

	Disabled	Non-disabled	Unknown
Total %	-	75%	25%

The data indicates no staff declaring a disability has been involved in the Grievance process.

1.8 Disability and Access to Training

Courses	Disability					
	Yes		No		Undefined / Undisclosed	
Leadership (EMLA)	-	-	72	100%	-	-
Leadership (UHL)	-	-	59	95%	3	5%
Short Courses	6	0.6%	661	73%	240	26%
QCF's	5 **	6%	82	93%	1	1%
Apprentices	3**	7%	43	93%	-	-

The data indicates that staff declaring a disability are not accessing Leadership courses.

Due the recording methods we know that although no staff undertaking training through the Qualifications and Credit Framework (QCF) or Apprenticeship declared a disability:
**8 QCF learners/ Apprentices did register as having 'other medical condition' and
6 QCF learners/ Apprentices did register as having additional learning needs (Dyslexia / Dyscalculia)

Summary

Within the organisation we have continued to see an increase in staff declaring a disability there remains, however, approximately one third of the workforce who's status is unknown and therefore we remain unable to draw any firm conclusions from the data. Monitoring data gathered from other sources in the Trust suggest the percentage of staff that would be covered under the Equality Act (2010) definition of disability is higher. It is hoped that these two issues will be resolved following the planned ESR update.

The data we have demonstrates:

- We have staff declaring a disability in all staff groups and across most pay bands with the exception of senior staff of band 8C-9.
- During the recruitment process non-disabled staff are more successful than disabled staff. This has not been seen in previous year's data. This year 2.5% of new starters had a disability compared to 4% last year.
- There is above expected representation of staff with a disability leaving the Trust but the figure is consistent with last year.
- Again this year there is an over representation of disabled staff who have been involved in a disciplinary procedure.
- Staff declaring a disability are under represented in areas of voluntary training however the recording of data is inconsistent.

Key actions

- To complete the Electronic Staff Record (ESR) update.
- To monitor trends in recruitment data.
- To review the disciplinary cases to ensure equity.

Section 2 – Sex (formally referred to as gender)

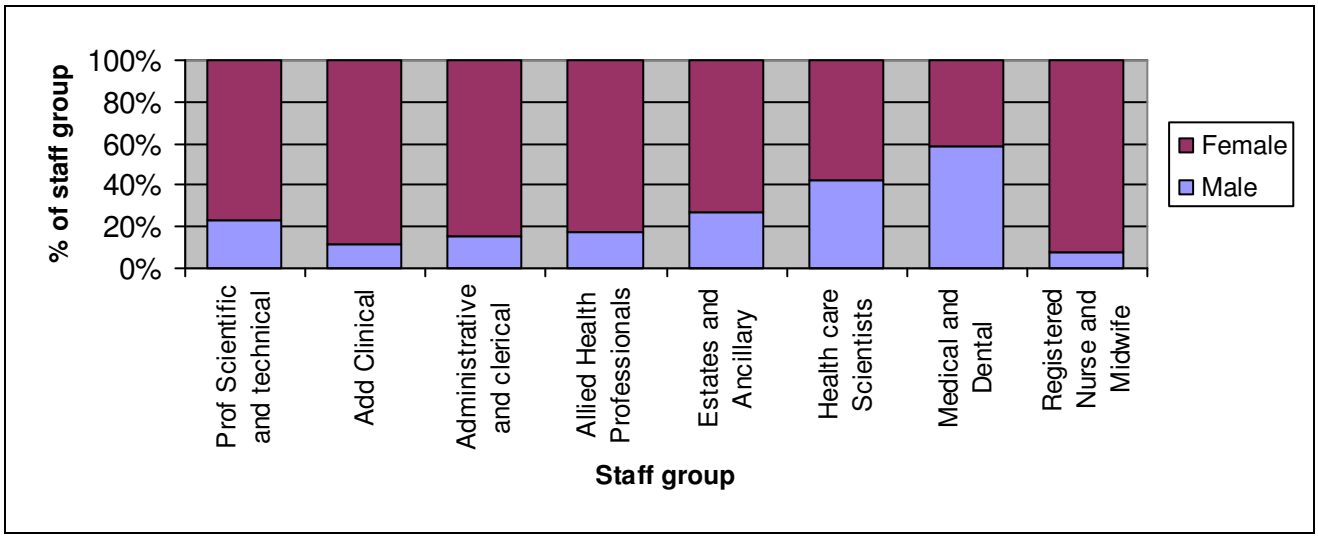
Under the Equality Act (2010) the term ''sex'' has replaced gender.

2.1 Sex profile of staff in post.

Year ending	March 2014	March 2013	% of change
Female	79.6%	79.2%	+0.4%
Male	20.4%	20.8%	-0.4%

The data shows a small percentage rise in female staff compared to last years data. This is consistent with national figures.

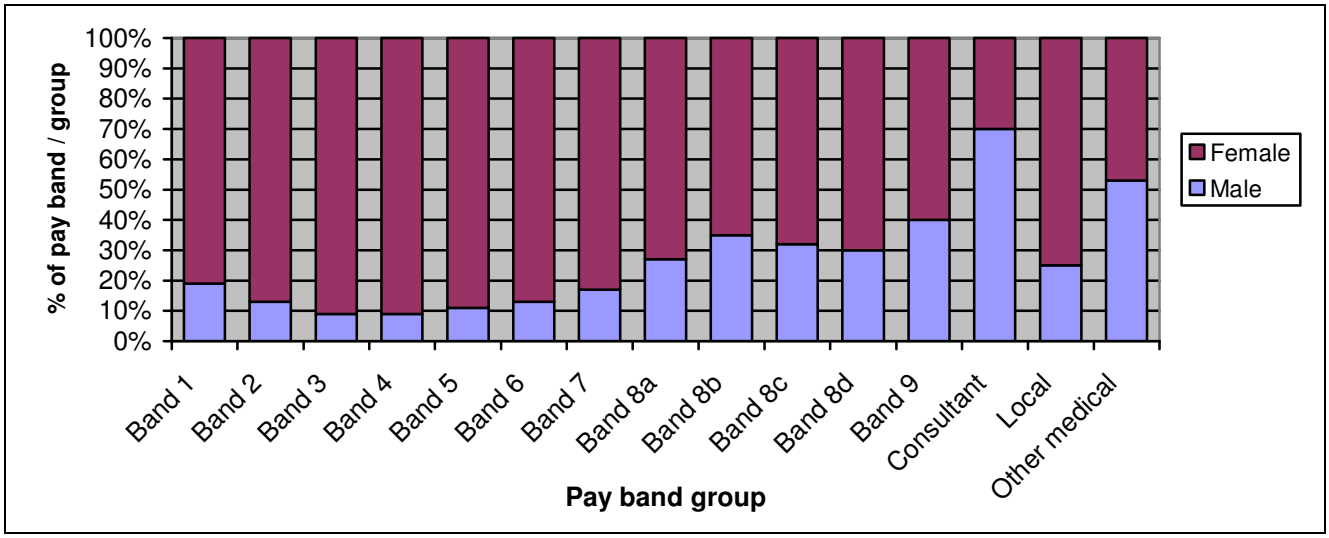
Sex as a Proportion of Staff Group



The data demonstrates that when compared to last years data there has been some percentage change in all staff groups except for Additional Clinical and Healthcare Scientists. The most notable of these are:

- Prof Scientific and Technical which has seen a 3% increase in female staff.
- Estates and Ancillary which has seen a 3% increase in male staff.

2.2 Sex Profile and Pay



The data continues to demonstrate an overall trend of decreasing female representation and increasing male representation as a proportion as the pay band increases.

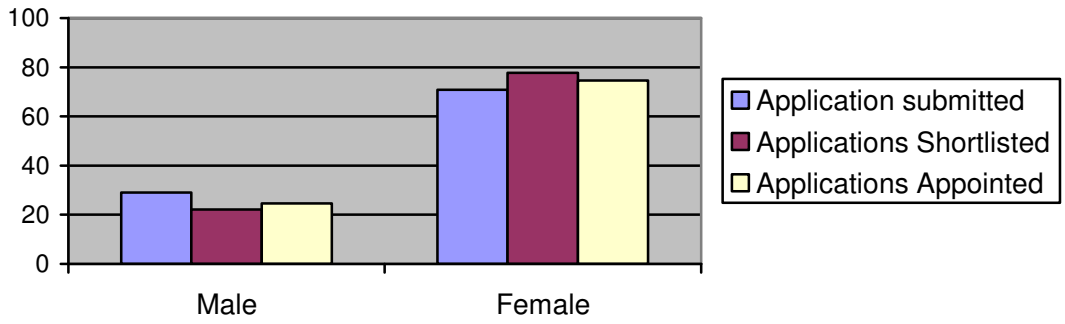
When compared to last years data there is:

- An overall increase of 2 % in male representation in bands 1-4.
- Status quo in bands 5-7 and other medical groups
- An increase in female representation in bands 8a; 8c; 8d; and those on local pay of between 2 – 9%
- A 0.7% increase in female consultant appointments however this is due to growth in the overall Consultant population.

"Local" pay bands include staff on the previous Trust pay scales, apprentices and senior management.

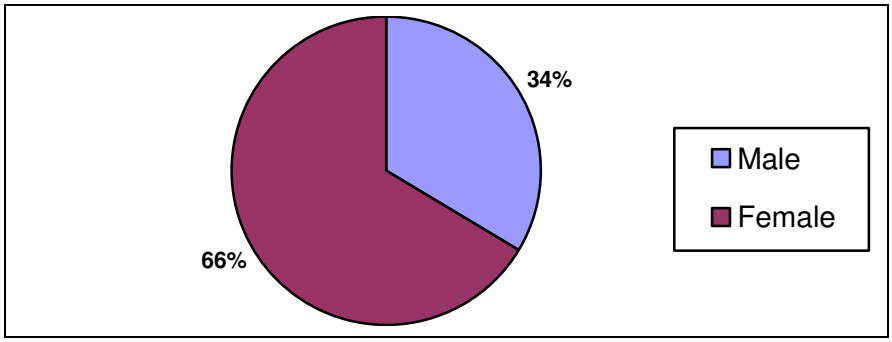
2.3 Sex Profile at Recruitment

Percentages of the sex of applicants at each stage of recruitment process



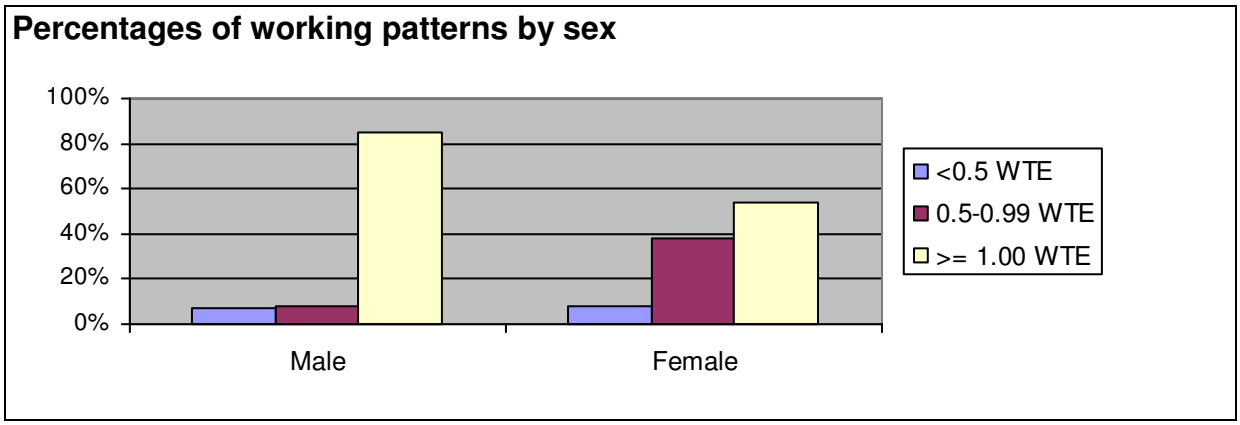
The data indicates that less male applicants are shortlisted from applications submitted. However the appointment from shortlist, demonstrates males to be more successful.

2.4 Sex of Staff Leaving



There is little change this year in the percentage of each gender leaving the Trust. This indicates that more male staff than expected based on representation have left the Trust. Further analysis of the data indicates that of males leaving the Trust over 50% is due to 'end of fixed term contracts'. Whilst for females leaving the Trust 50% do so following voluntary resignation.

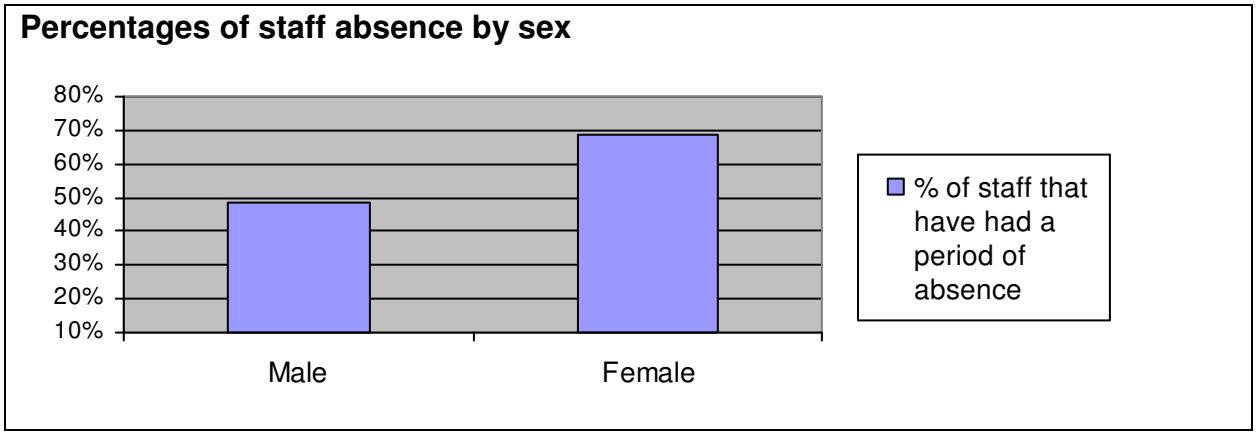
2.5 Working Patterns



The data demonstrates that:

- Significantly more male staff work full time
- Significantly more female staff work between 0.5 – 0.99 WTE
- There is little difference in genders working less than 0.5 WTE

2.6 Sickness and Absence



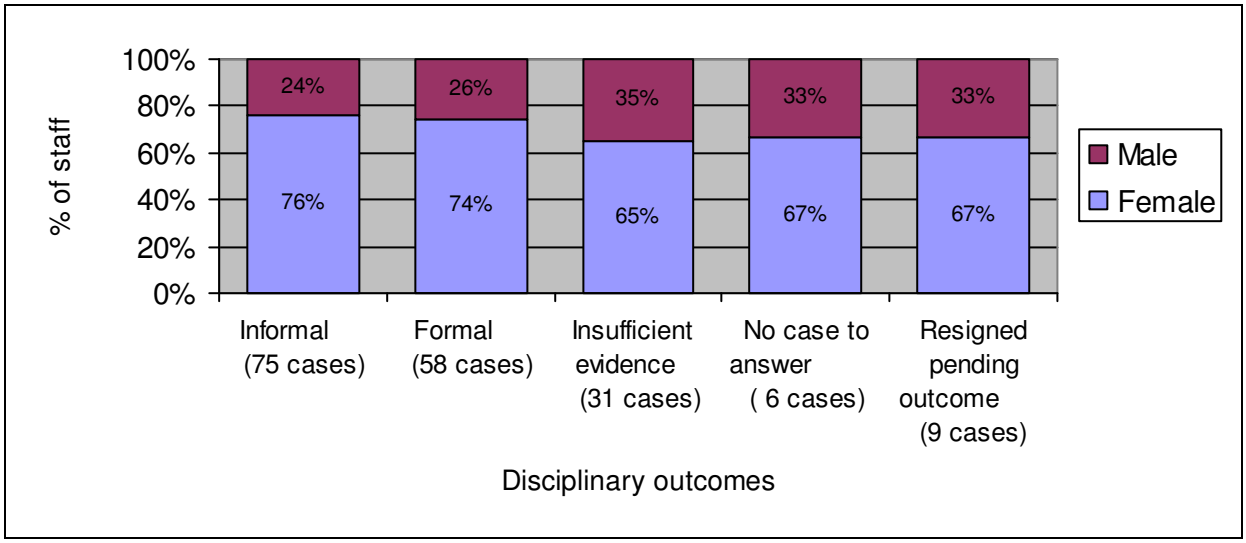
The data indicates the percentage of staff who have taken a period of sickness is higher amongst female staff.

2.7 Sex Profile and Disciplinary and Grievance

A total number of 179 disciplinary processes and 12 grievance cases were concluded during 2013-2014.

Disciplinary data by sex.

	Female	Male
Total %	73%	27%



The data suggests that more male staff than expected based on representation are involved in the disciplinary process. This is most evident where it's found that there has been 'insufficient evidence'.

Grievance Outcome Data by sex

	Total cases	Female		Male	
Total %	12	10	83%	2	17%

Of twelve grievance cases were brought, ten were not upheld and two were upheld in part. Of those upheld in part one was brought by a male and one by a female.

2.8 Sex Profile and Access to Training

Courses	Sex			
	Male		Female	
Leadership (EMLA)	25	35%	47	65%
Leadership (UHL)	17	27%	45	73%
Day Courses	110	12%	787	88%
QCF's	14	16%	74	84%
Apprentices	10	22%	36	78%

Summary

The sex makeup of or total workforce has remained consistent with previous data.

The detailed data demonstrates:

- There has been a percentage change sex representation in most staff groups.
- An overall trend of decreasing female representation and increasing male representation, as a proportion, as the pay band increases. There has however been some increase of female representation at senior level and amongst consultants.
- During recruitment the highest proportion of applicants are female, but from shortlist to appointment male applicants are more successful.
- There is an over representation of male staff leaving the Trust.
- More female staff work part- time hours.
- More female staff took a period of sickness.
- Male staff are over represented in the disciplinary process.
- An under representation of male staff undertaking attended internal short courses training and female staff attending leadership courses.

Key Action

- To look at access of females to leadership and management courses

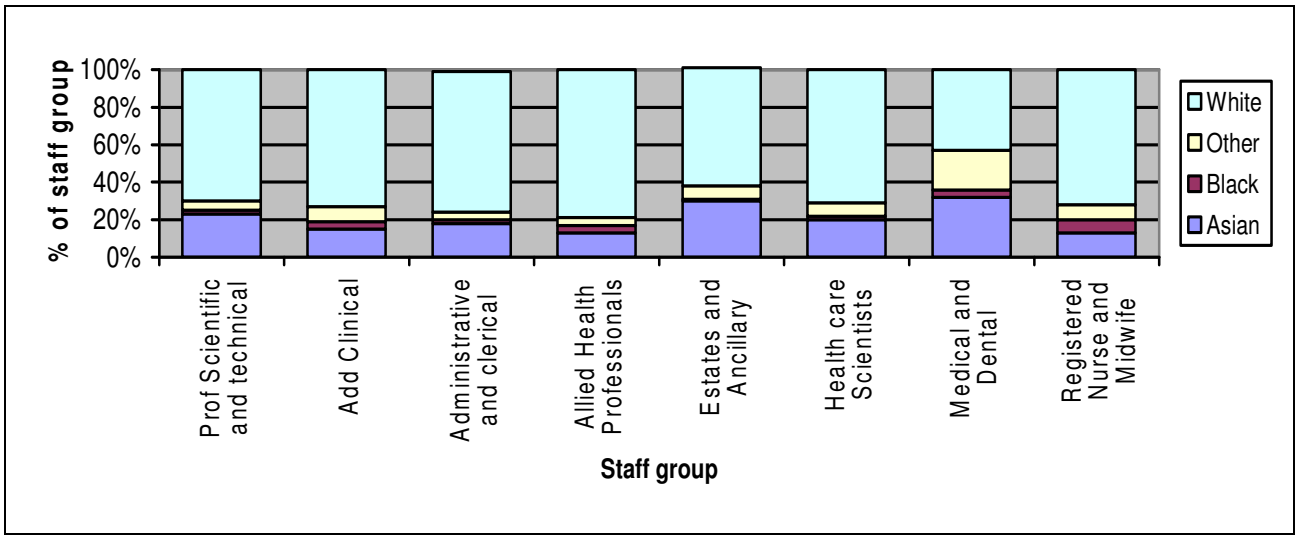
Section 3 – Race

3.1 Race Profile of Staff in Post.

	2014	2013	Percentage of change
Asian	18%	17%	+1%
Black	5%	4%	+1%
Other	9%	11%	-2%
White	68%	68%	-

The data indicates that the percentage of staff from a Black and Minority Ethnic (BME) (32%) and white (68%) background remains unchanged. There have however been some changes in the racial profile of our BME staff with an increase in staff numbers with an Asian or Black background and corresponding decrease in staff from an 'other' background.

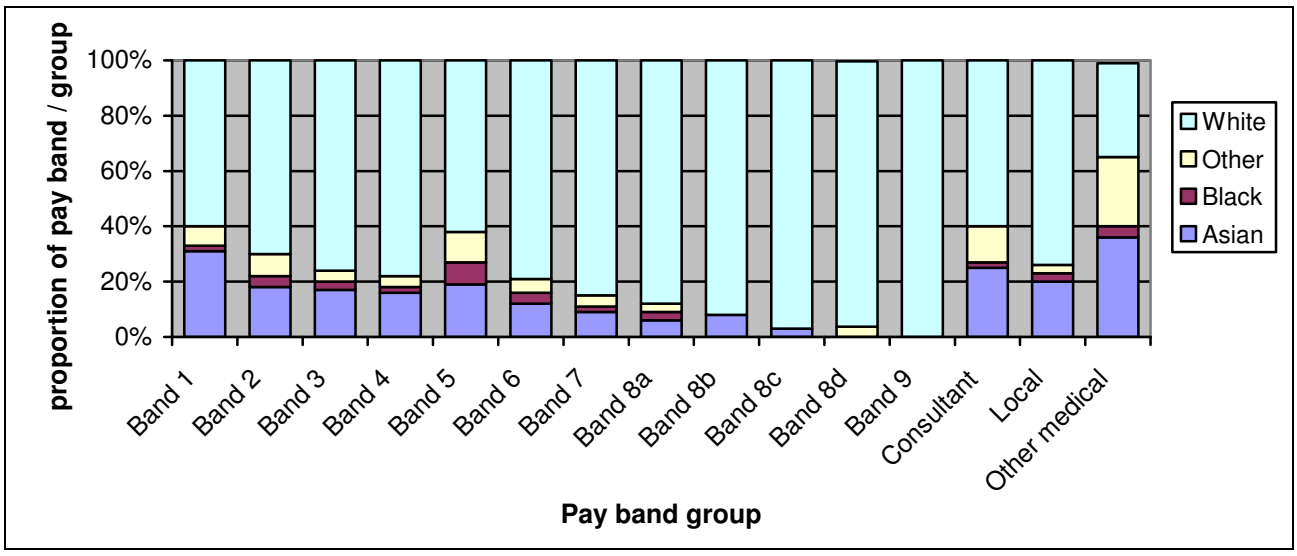
Race profile as a Proportion of Staff Group



The data continues to show representation in all staff groups.
The notable changes from last years data are:

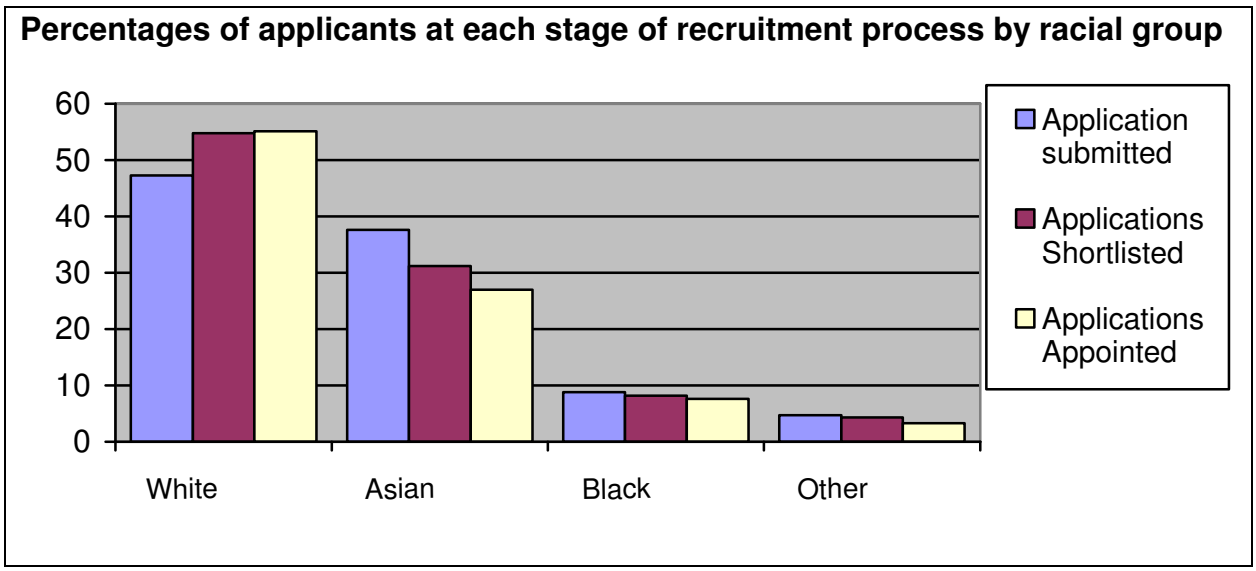
- 3% increase in Asian staff in professional scientific and technical
- 2% increase in Estates and Ancillary staff from 'other' group
- 3% increase in white staff in Health care Scientitists
- 7% decrease in medical and dental staff from 'Other' background with percentage increases in all other groups.

3.2 Race and Pay



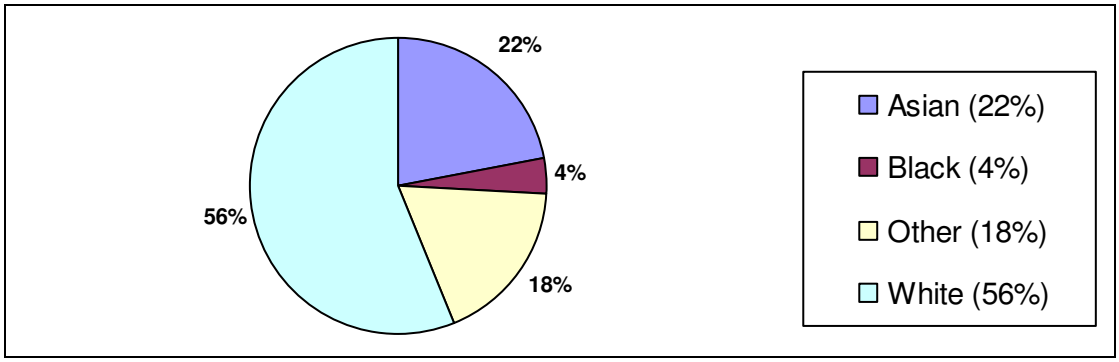
The data demonstrates that although there has been some change in the racial makeup of the BME groups overall representation remains static. BME representation remains low in Bands 8b-8d however this year it is only absent in band 9. From our deep dive work into BME representation at band 7 whilst we are seeing an upward trend within Nursing, we know that significant change is unlikely to be seen on a yearly basis.

3.3 Race Profile at Recruitment



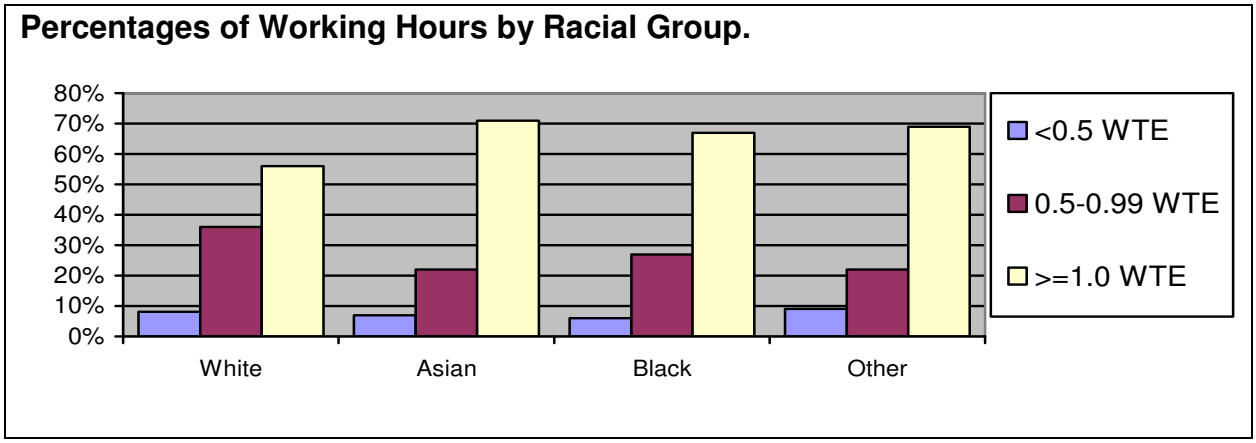
In a change to previous years, this year's data demonstrates that although applicants from a White background continue to do better from application to shortlisting, there is now significantly less difference in all groups from shortlisting to appointment.

3.4 Race of Staff Leaving the Trust



The data indicates that there has been a percentage decrease in staff leaving the trust in all groups with the exception of 'other'. In terms of workforce representation those from an Asian or 'other' staff are over represented with white staff under represented. In the 'other' group we have seen a significant change with a 10% increase of staff leaving, on more detailed examination of the data the reason for over half of this group was due to 'end of fixed term contract'.

3.5 Working Patterns

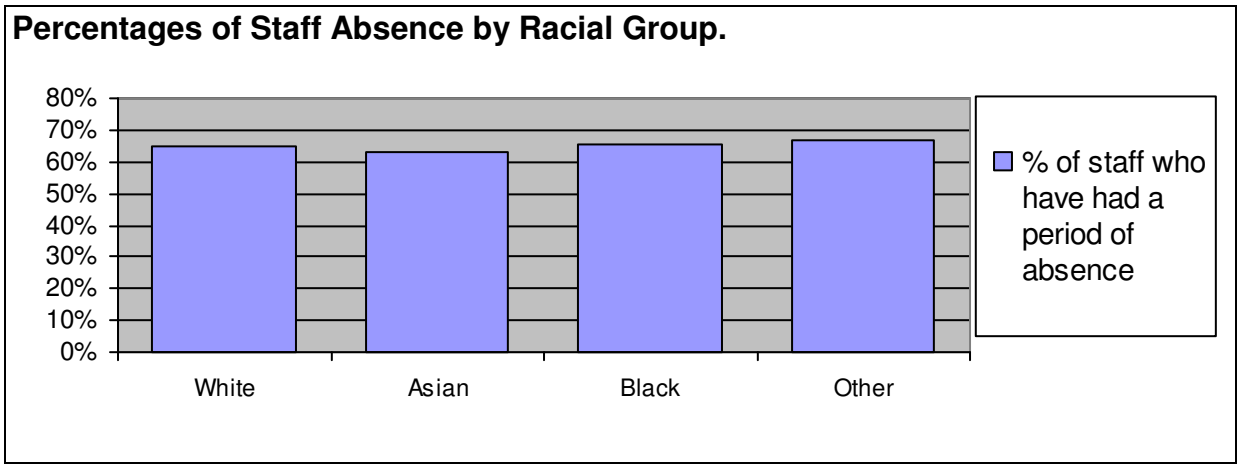


The data demonstrates that flexible hours are worked by all racial groups:

- >65% of BME staff work full time compared to 56% of white staff
- There is a higher percentage of staff from a white background work between 0.5- 0.99WTE.
- In all groups <10% of staff work less than half time.

3.6 Sickness and Absence

Percentages of Staff Absence by Racial Group.



There is no significant percentage difference between racial groups of staff taking a period of sickness.

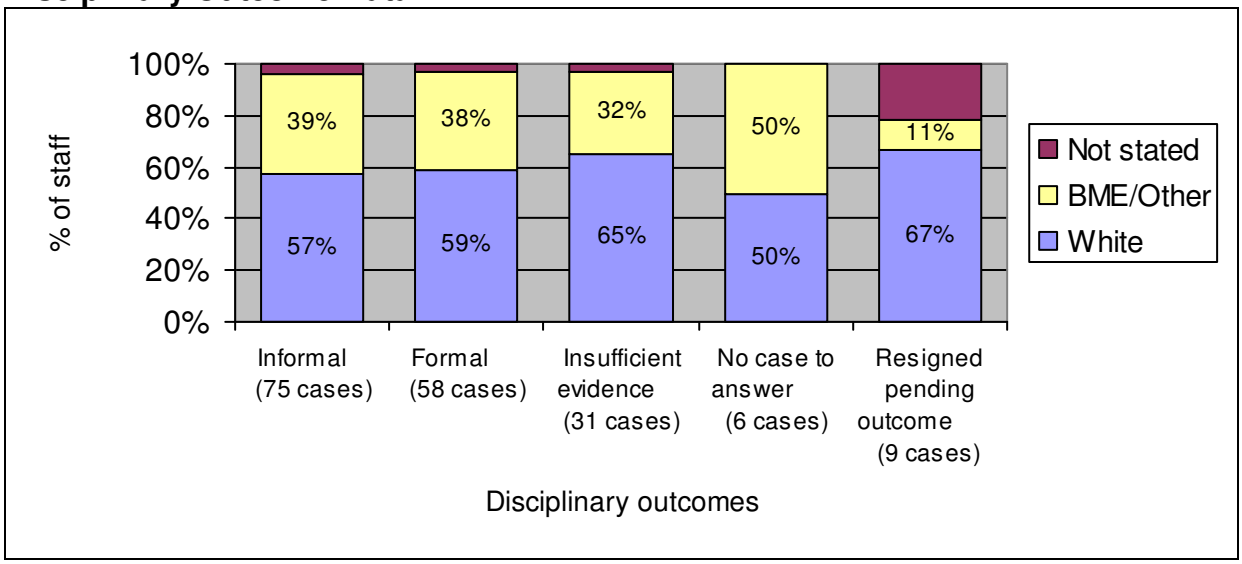
3.7 Disciplinary and Grievance by Race

A total number of 179 disciplinary processes and 12 grievance cases were concluded during 2013-2014.

Disciplinary data by Race.

Racial group	White	BME / Other	Unknown
Total %	59%	36%	5%

Disciplinary Outcome Data



The data indicates that there is a higher than expected BME representation in disciplinary cases. In comparison to last years data there is a higher BME representation in all outcome groups with the exception of those choosing to resign which has reduced. The small numbers within this group do not allow any meaningful conclusions to be drawn from this.

Grievance cases by race

Ethnic group	White		BME / Other	
Total %	10	83%	2	17%

Of the twelve grievance cases were brought, ten were not upheld and two were upheld in part. Both of the cases upheld in part were by white staff members.

3.8 Ethnicity and Access to Training

Courses	**Ethnicity**					
	White		BME /Other		Undefined/ Undisclosed	
Leadership (EMLA)	48	67%	1	1%	23	32%
Leadership (UHL)	50	81%	7	11%	5	8%
Short Courses	567	62%	117	13%	223	25%
QCF	72	81%	12	14%	4	5%
Apprentices	27	59%	18	39%	1	2%

The data demonstrates under representation of BME attending all training courses with the exception of apprenticeships when compared with the workforce population.

Summary

The data indicates that our overall workforce percentage of BME representation has remained stable. There is evidence however that within it there has been a change in the racial profile with a percentage increase in both Asian and black staff and corresponding decrease in 'other'.

The detailed data demonstrates:

- There has been a percentage change in representation in most staff groups. The most notable is a decrease of 7% in the 'Other' category within Medical and dental.
- An overall trend of decreasing representation of staff from a BME background (with the exception of band 5) as the pay band increases. There is however now only absence of any BME representation at Band 9.
- Within medical staff we see an over representation of staff from a BME background in relation to total workforce figures.
- This year's recruitment data demonstrates that although applicants from a white continue to better through the application process, there is now significantly less difference in all groups from shortlisting to appointment.
- There is an over representation of BME staff leaving the Trust this is particular evident amongst staff from an Asian or 'other' background. Some of this appears to be due to rotation of medical staff.
- Flexible working hours are demonstrated within all groups of these a higher proportion of white staff work less that full time hours.

- There is minimal difference between racial groups in the percentage of staff taking a period of sickness.
- There is an over representation of BME staff involved in the disciplinary process than what we would expect from our workforce population.
- An under representation of staff from a BME background undertaking recorded training with the exception of Apprentices.

Key Actions

- Look at access to leadership and training courses
- Representation in other Professional Groups at senior level

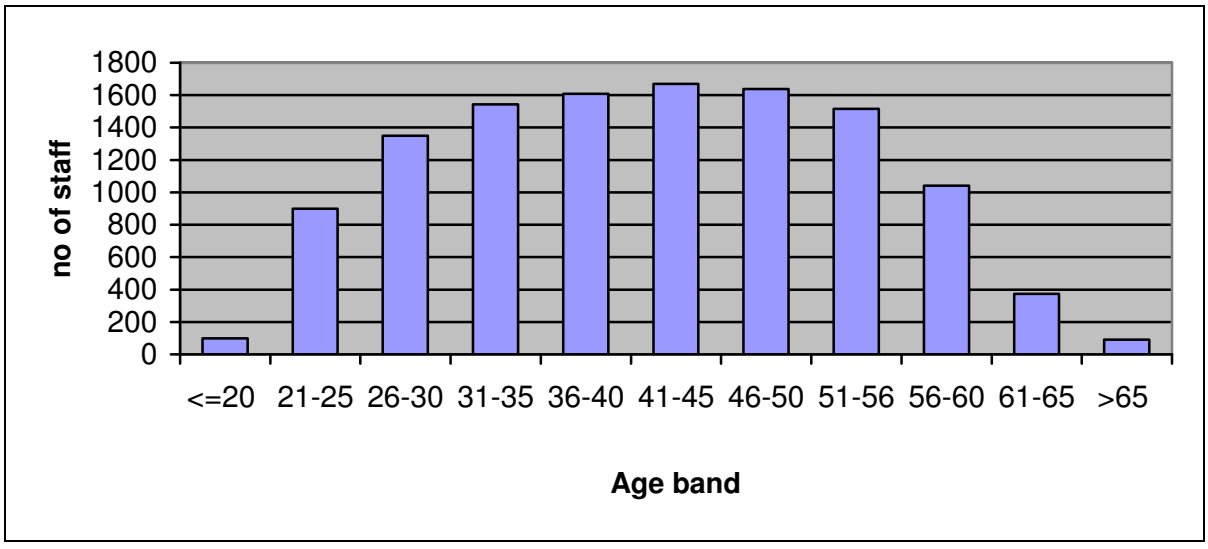
Section 4 – Age

4.1 Age Profile of Staff in Post.

Year ending	March 2014	March 2013	% of change
<20 yrs	0.8%	0.6%	+0.2%
21-25yrs	8%	7%	+1%
26-30yrs	11%	11%	-
31-35yrs	13%	13%	-
36-40yrs	14%	14%	-
41-45yrs	14%	14%	-
46-50yrs	14%	15%	-1%
51-55yrs	13%	13%	-
56-60yrs	9%	9%	-
61-65yrs	3%	3%	-
>65yrs	0.8%	0.6%	+0.2%

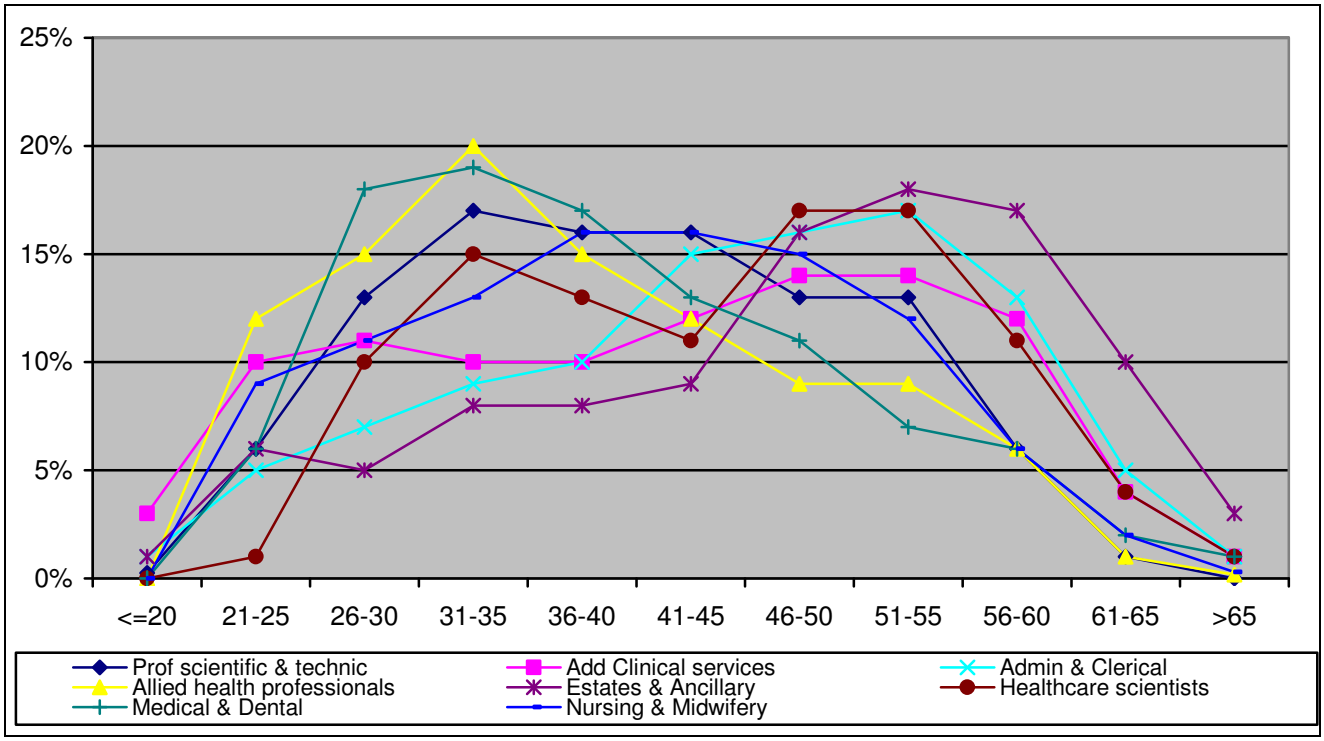
The data demonstrates minimal changes in the percentage of staff within each age bracket.

Age profile of the workforce



The age profile of staff has remained stable over the last twelve months with data demonstrating a normal distribution across age groups with the majority of staff falling between 36 -50yrs

Age Profile of Staff Groups.

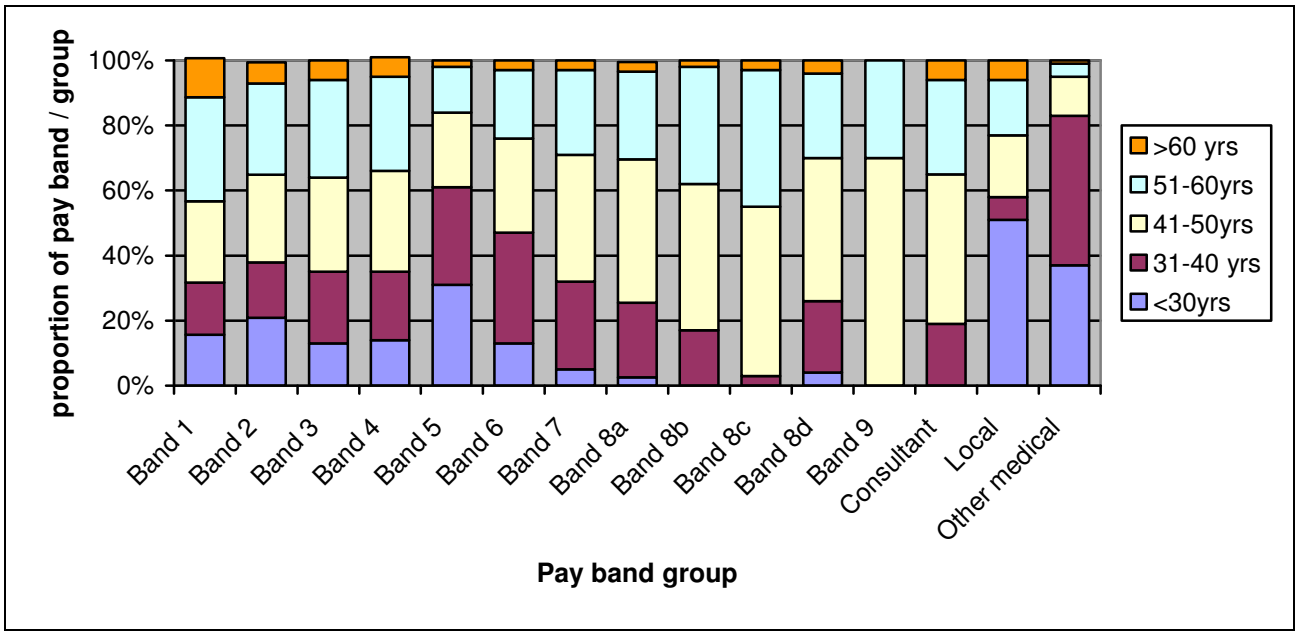


The data indicates there are two noticeable peaks within the staff groups:

- 31-35yrs these include Allied Health Professionals, Medical and Dental, Professional Scientific and Technical
- 50-55yrs which includes the staff groups Estates and Ancillary, Administration and Clerical and Heath Care Scientists.

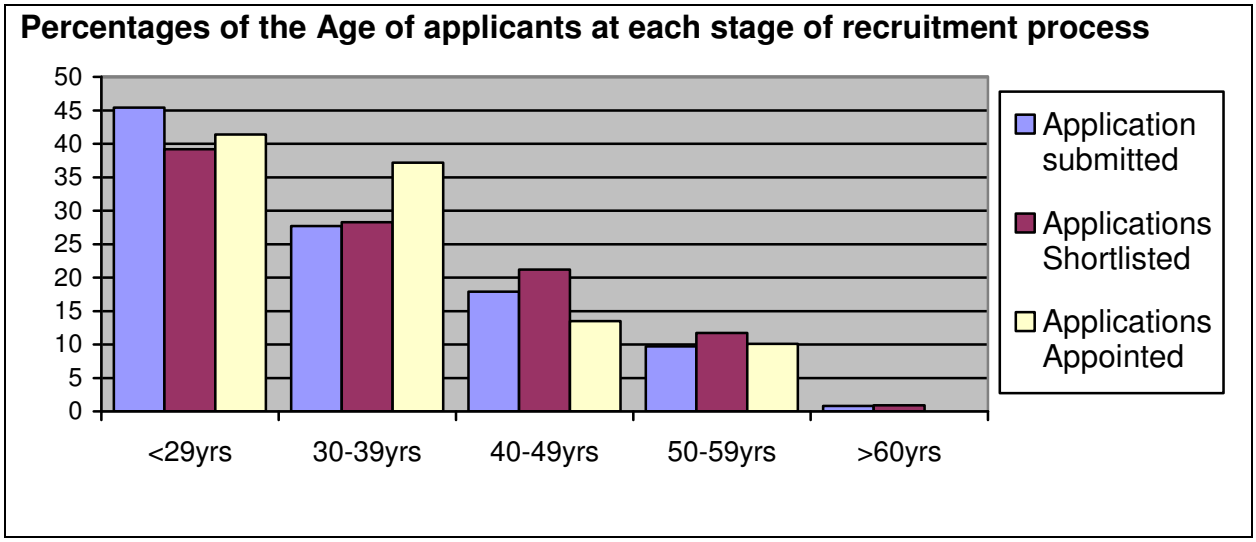
Nursing and Midwifery as our largest staff group follow the pattern of overall workforce representation.

4.2 Age and Pay



The data continues to show good age representation across all bands, with the expected fewer younger staff (aged< 30yrs) in senior positions.

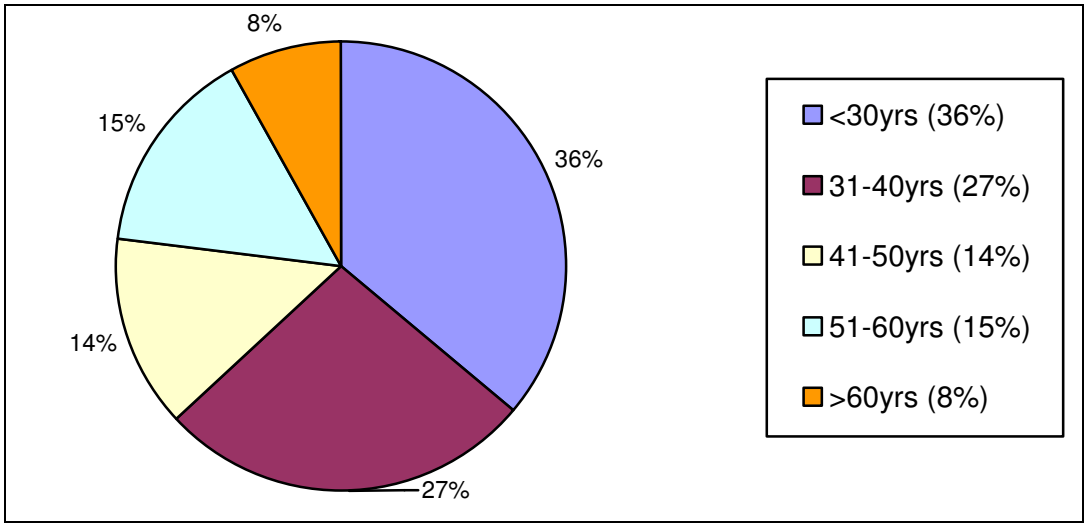
4.3 Age Profile at Recruitment



The data shows that:

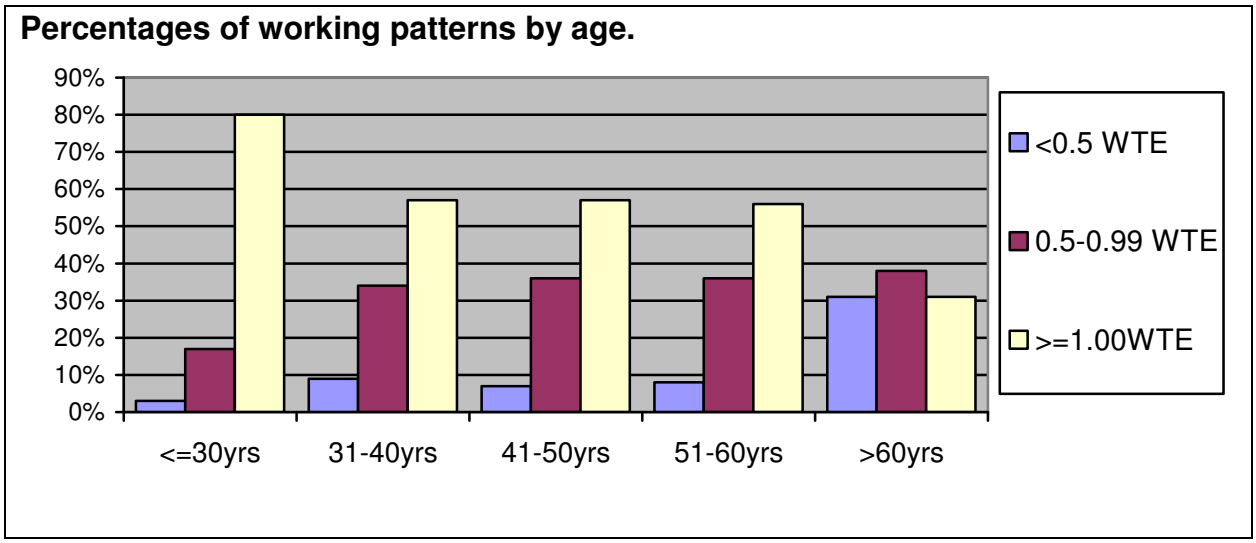
- The highest percentage of applications submitted comes from individuals aged less than 29yrs.
- The percentage of applications submitted decreases as age bracket increases.
- A higher percentage of those aged between 30-59yrs are shortlisted from application.
- From short listing to appointment those aged between <29yrs - 39yrs are the most successful. This was not seen in the 30-39yrs data last year.

4.4 Age of Staff Leaving



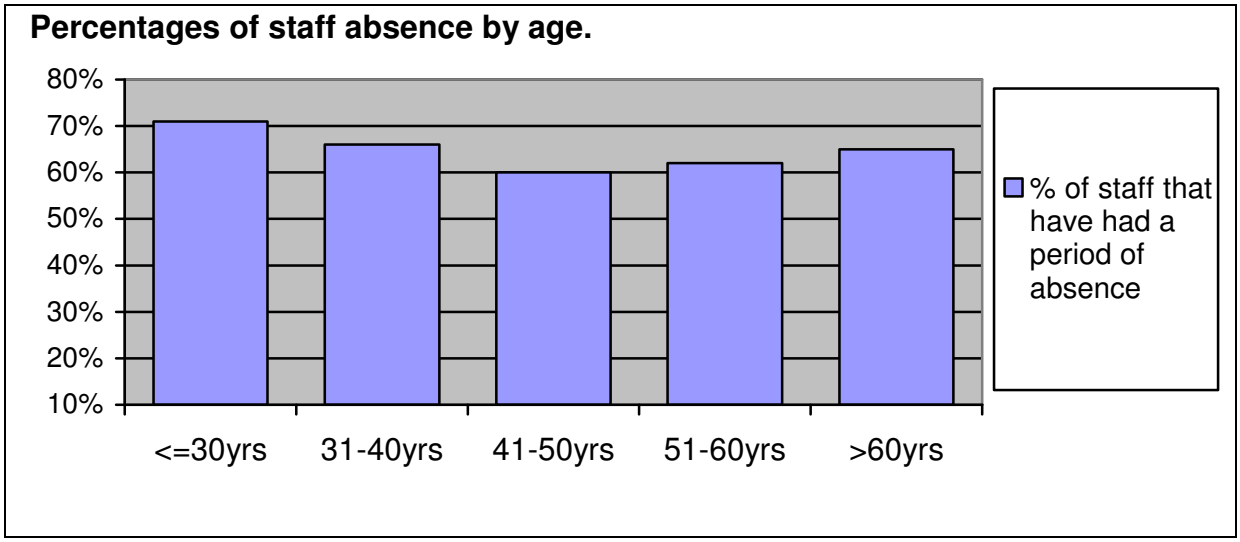
This year's data shows a difference in the percentages of all age groups. There is an increase of 10% of those <30 leaving, with a corresponding decrease in those above 41yrs. This is mainly due to last years data containing a large employee transfer involving many staff in above 41yrs.

4.5 Working Patterns



The data demonstrates that there is flexible working across the age ranges.
The most marked differences in hours worked can be seen at either end of the age range with 80% of those aged 30yrs or less working full time compared with 36% of those aged over 60 yrs.

4.6 Sickness and Absence



The data indicates that those aged 30yrs or less have the highest percentage (71%) of staff taking a period of sickness. The lowest (60%) was demonstrated in those in the 41-50 yr old age bracket.

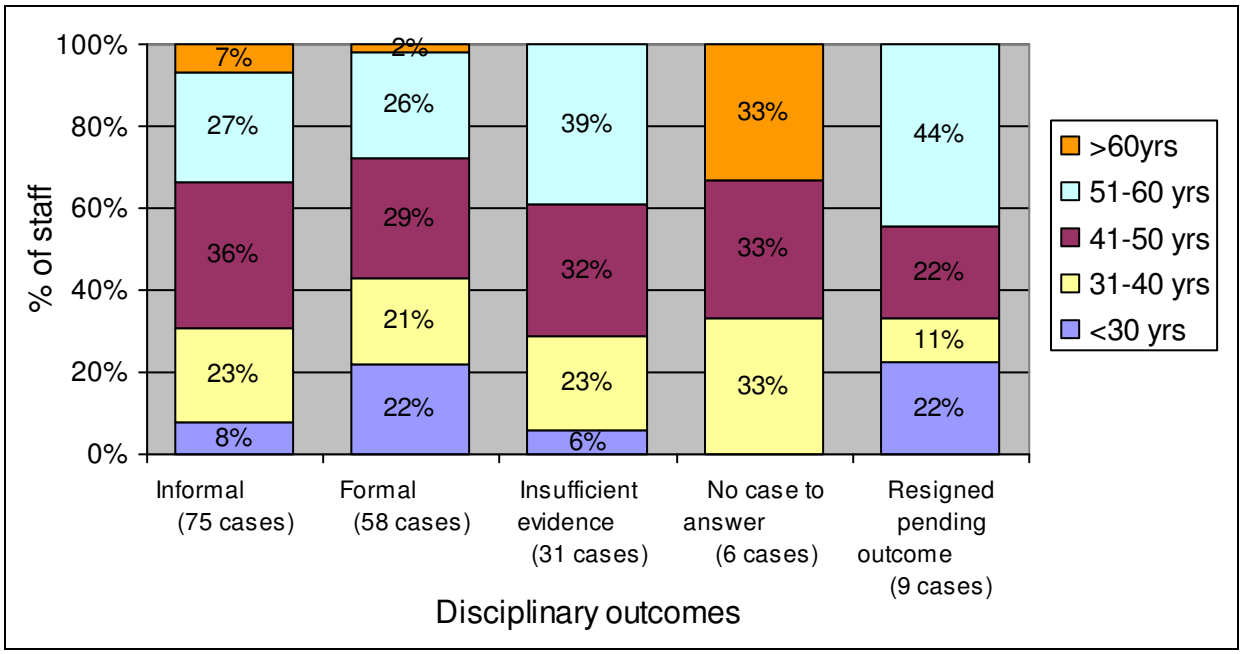
4.7 Disciplinary and Grievance

A total number of 179 disciplinary cases and 12 grievances were concluded during 2013-2014.

Disciplinary data by Age group.

Age band	<=30yrs	31-40yrs	41-50yrs	51-60yrs	>60yrs
Total %	13%	22%	32%	28%	4%

Disciplinary category outcomes by age.



The data shows that:

- There is a higher than expected representation of staff aged >60yrs involved in disciplinary cases with a formal outcome.
- There is a higher than expected representation of staff aged 41-50yr involved in disciplinary cases with an informal outcome.
- There is a higher than expected representation of staff aged 51 -60yrs involved in disciplinary cases where the outcome found there was insufficient evidence.
- There is a higher than expected representation of staff in all represented age groups involved in disciplinary cases where it is found that there is no case to answer**.
- There is a higher than expected representation of staff above the age of 51yrs that choose to resign before an outcome was determined**.

**NB numbers in these categories are small.

Grievances

	Total cases	**<30 yrs**		**31-40yrs**		**41-50yrs**		**51-60yrs**		**>60yrs**	
Total %	12	1	8%	2	17%	4	33%	4	33%	1	8%

Of the twelve grievance cases, ten were not upheld and two were upheld in part. Of those upheld in part one was brought by a member of staff <30yrs and one aged 51-60yrs.

4.8 Age and Access to Training

Training	**Age groups**				
	<20yrs	20-31yrs	32-40yrs	40-51 yrs	>52yrs
Leadership (EMLA)	Age data recorded differently data demonstrated: <44yrs =16 (22%); 45-64yrs =23 (32%); undisclosed = 33 (46%)				
Leadership	*Age is not recorded				

(UHL)										
Short Courses	*Age is not recorded									
QCF learners	-	-	34	39%	26	30%	19	21%	9	10%
Apprentices	13	28%	31	67%	1	2%	1	2%	-	-

4.9 The 5 Year Plan and the Aging Workforce

This is an additional area for this year's workforce report. Our data shows that 22% of staff are aged between 51-65yrs with many eligible for retirement over the next five years. We know that there is a particular problem in relation to Midwives that has previously been reported and detailed in the Women's and Children's work plan. The 5 year workforce plan acknowledges that there may be other staff groups for example Healthcare Scientists and Consultants that may be affected by a larger numbers of retirements than previously seen. It is important that as a Trust we have robust retirement plans in place. To this end a task and finish group will be established in the New Year to ensure that adequate plans are in or can be put into place.

Summary

The data indicates stability in our age profile across the workforce with the peek of staff between 36 -50 yrs of age.

The detailed data demonstrates:

- A representation of all age bands across staff groups with distinct peaks in some staff groups.
- Within the recruitment process applicants under the age of 29yrs are most prominent. Those most successful from shortlisting to application are <39yrs.
- Expected patterns in the age profile of staff leaving the Trust with an over representation in staff aged <30yrs as many are in training posts or >60 yrs as individuals retire.
- There is flexible working seen across all age groups with a higher percentage of staff aged <30yrs working full time and the highest percentage of staff >60 yrs working part time.
- A higher percentage of staff <30yrs have taken a period of sickness.
- All age groups are represented in the disciplinary process. Each category outcome however demonstrates an over representation of a different age bracket.
- The data demonstrates that 22% of staff is aged between 51-65yrs with many eligible for retirement over the next five years.

Key Actions – Points to consider

- Aging workforce link into 5 year workforce and midwifery plans.

Section 5 – Sexual Orientation

In a 2010 national integrated household survey conducted by the Office of National Statistics, 94% of those questioned identified themselves as heterosexual, 1%

identified as Gay or Lesbian, 0.5% as Bisexual and the remaining 0.5% as other. This would suggest that individuals who identify nationally as LGB is 1.5%.

5.1 Sexual Orientation Profile of Staff in Post.

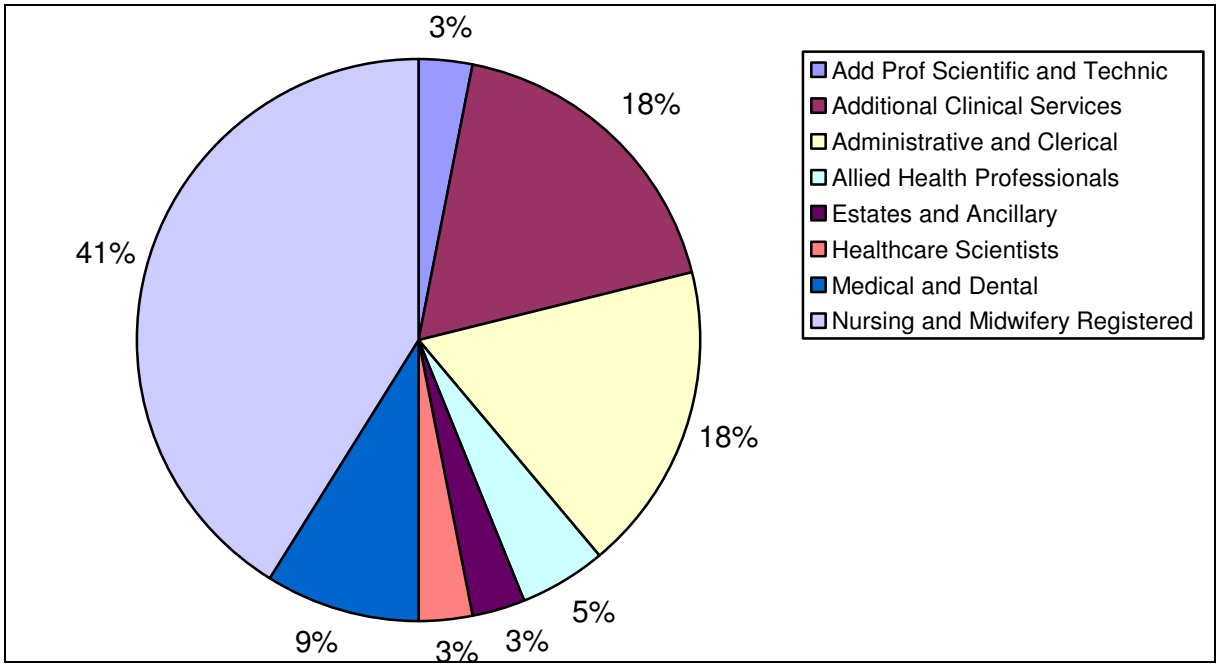
Year ending	March 2014	March 2013	% of change
Bisexual	0.52%	0.49%	+0.03
Gay	0.47%	0.37%	+0.1
Heterosexual	61.34%	53.19%	+8.15
Lesbian	0.27%	0.23%	+0.04
Do not wish to declare	12.04%	13.2%	-1.16
Unknown	25.36%	32.6%	-7.24

*148 staff declared as Lesbian, Gay, Bisexual (LGB) = 1.25% staff population

The data shows that this year we have seen a further percentage decrease in staff with an undefined sexual orientation status. Alongside this we have also seen a percentage reduction in those who 'do not wish to disclose' their sexual orientation.

The representation of individuals identifying as LGB in our staff population is reflective of that seen in the population as a whole.

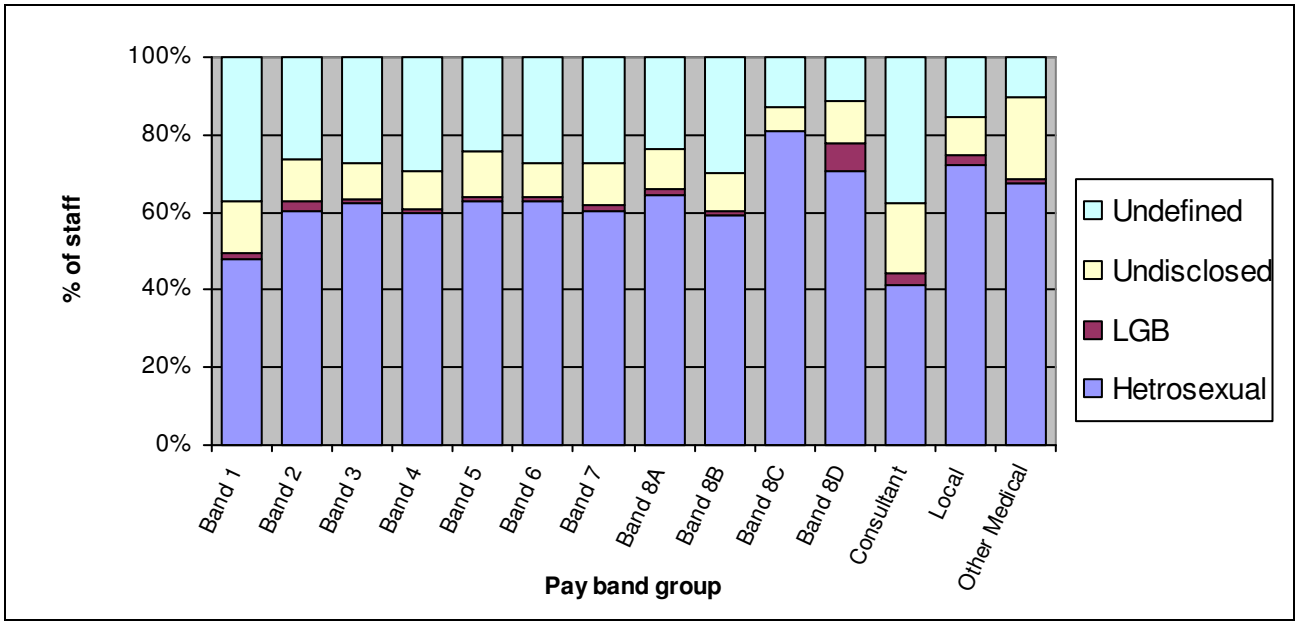
Comparison of the Percentage of staff declaring as LGB in each staff group.



The data indicates that there is LGB representation in all staff groups. When considered alongside workforce representation of staff groups.

- Nursing and midwifery are over represented
- Medical and dental are under represented
- All other staff group are broadly representative

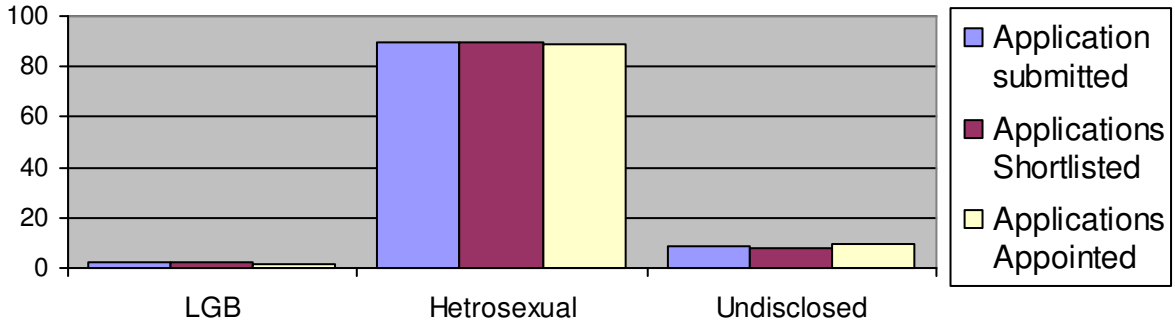
5.2 Sexual Orientation and Pay



There is representation of staff that identify themselves as LBG across all pay bands with the exception of bands 8C and 9. This year's data shows an increase in Consultant representation and bands 8D.

5.3 Sexual Orientation Profile at Recruitment

Percentages of the sexual orientation of applicants at each stage of recruitment process

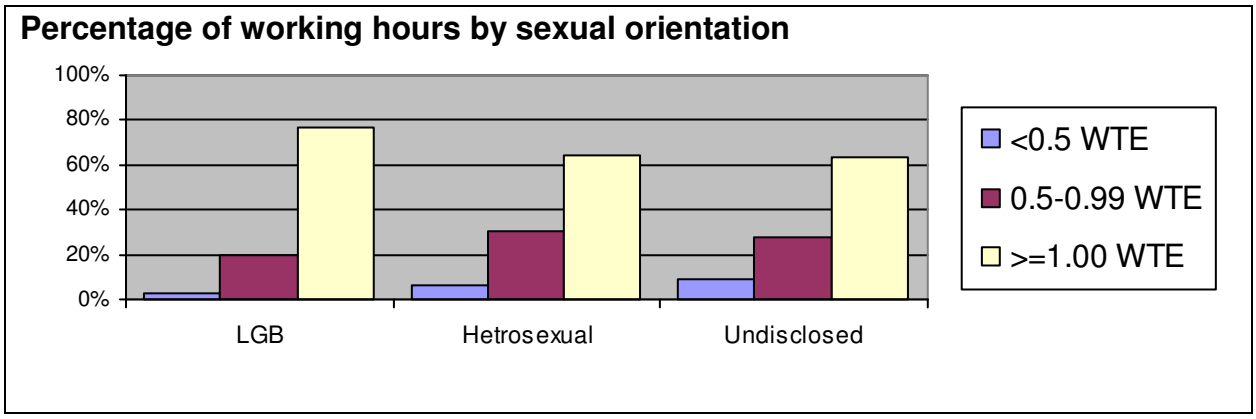


The data indicates that applicants who declare the sexual orientation are equally successful through each stage of the recruitment process. There remains just under 10% that do not disclose their sexual orientation.

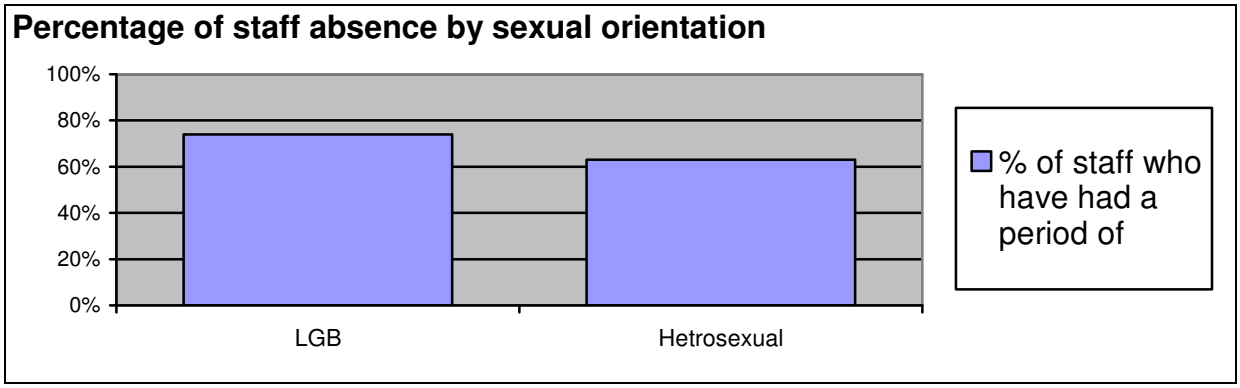
5.4 Sexual Orientation of staff leaving

Of staff that have left the Trust 1.14% (19 staff members) identified themselves as LGB. This figure is consistent with last year's representation. The reasons for leaving were varied with no evident pattern.

5.5 Working patterns



5.6 Sickness and Absence



The data indicates the percentage of staff who has taken a period of sickness is higher in staff who identify as LGB. Further analysis of the data revels that above workforce representation as a whole is only evident in staff identifying as Lesbian or Bisexual.

5.7 Disciplinary and Grievance

A total number of 179 disciplinary processes and 12 grievance cases were concluded during 2013-2014.

Disciplinary Data by Sexual Orientation.

	LGB		Heterosexual		Unknown	
Total %	2	1.12%	94	52.51%	83	46.37%

Due to the percentage of staff involved in the disciplinary process who's sexual orientation is unknown it is difficult to draw any firm conclusion from his data. The disciplinary processes involving staff identifying as LGB were both concluded informally.

Grievances

Of the twelve grievance cases, ten were not upheld and two were upheld in part. Of those upheld in part, one was raised by a member of staff identifying as LGB.

5.8 Sexual Orientation and Access to Training

Training	Sexual Orientation					
	LGB		Heterosexual		Undefined/ Undisclosed	
Leadership (EMLA)	-		35	49%	37	51%
Leadership (UHL)	-		51	82%	11	18%
Day Courses	2	0.2%	534	59%	371	41%
QCF's	Data unavailable					
Apprentices	2	4%	42	91%	2	4%

Summary

The data indicates a representation within the workforce as a whole, with percentages reflecting that of the population

The detailed data demonstrates:

- We have staff identifying as LGB in all staff groups and across most pay bands with the exception senior staff of band 8c and band 9.
- There is no discrimination within the recruitment process with 2% of new starters identifying as LGB.
- Staff identifying as LGB are less likely to work part time than those identifying as heterosexual.
- A higher percentage of staff identifying as Lesbian or Bisexual have taken a period of sickness.

Key Action – Points to consider

- To look at the access to training for LGB staff.

Section 6 – Religion or Belief

The Equality Act states it is unlawful to discriminate against workers because of their religion or belief or against a person for not holding a particular (or any) religious or philosophical belief.

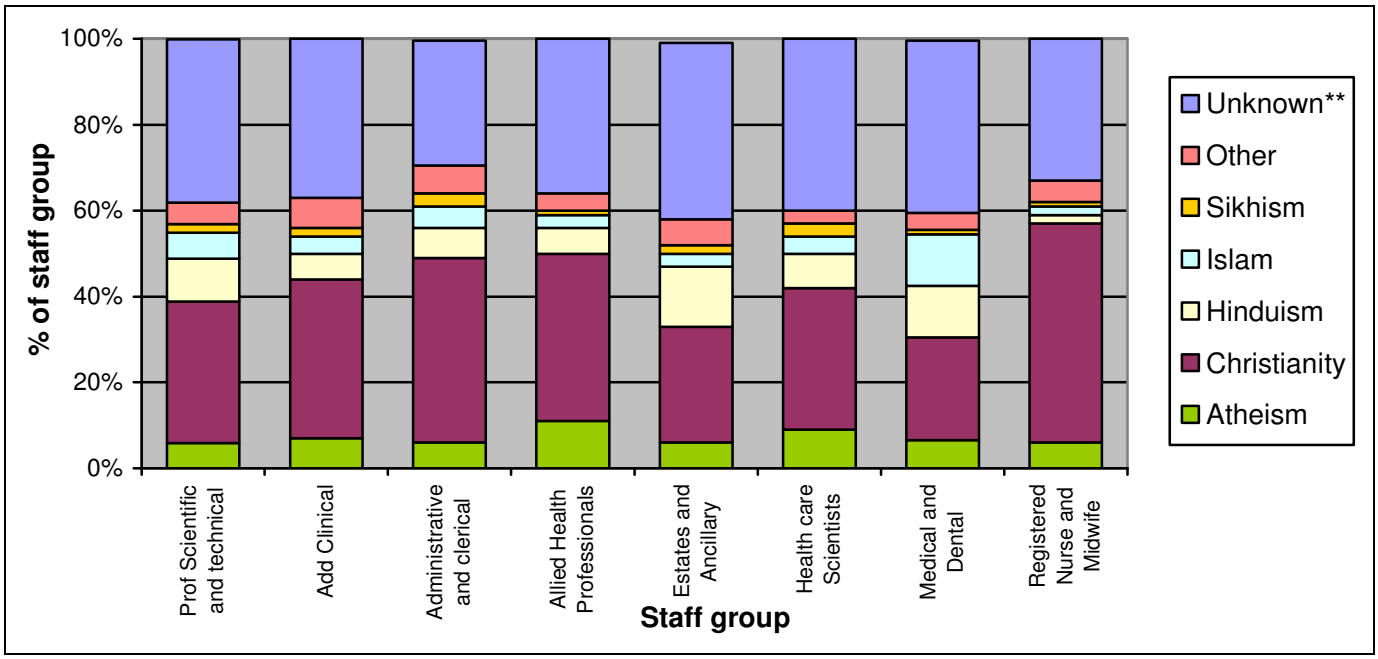
6.1 Religion or Belief Profile of Staff in Post.

	March 2014	March 2013	% of change
Atheism	6.7%	5.4%	+1.3%
Buddhism	0.4%	0.3%	+0.1%
Christianity	40.5%	38%	+2.5%
Hinduism	6.1%	5.4%	+0.7%
Islam	4.6%	3.3%	+1.3%
Jainism	0.1%	0.1%	-
Judaism	0.1%	0.1%	-
Sikhism	1.6%	1.3%	+0.3%
Other	4.8%	4%	+0.8%
Undefined	23.6%	31%	-7.4%

Not wish to disclose	11.5%	12%	-0.5%

There is a broad range of beliefs amongst staff. The data shows that we continue to increase the number of staff declarations for Religious and Belief. Profiles are undefined, this corresponds with most groups demonstrating a percentage increase this year.

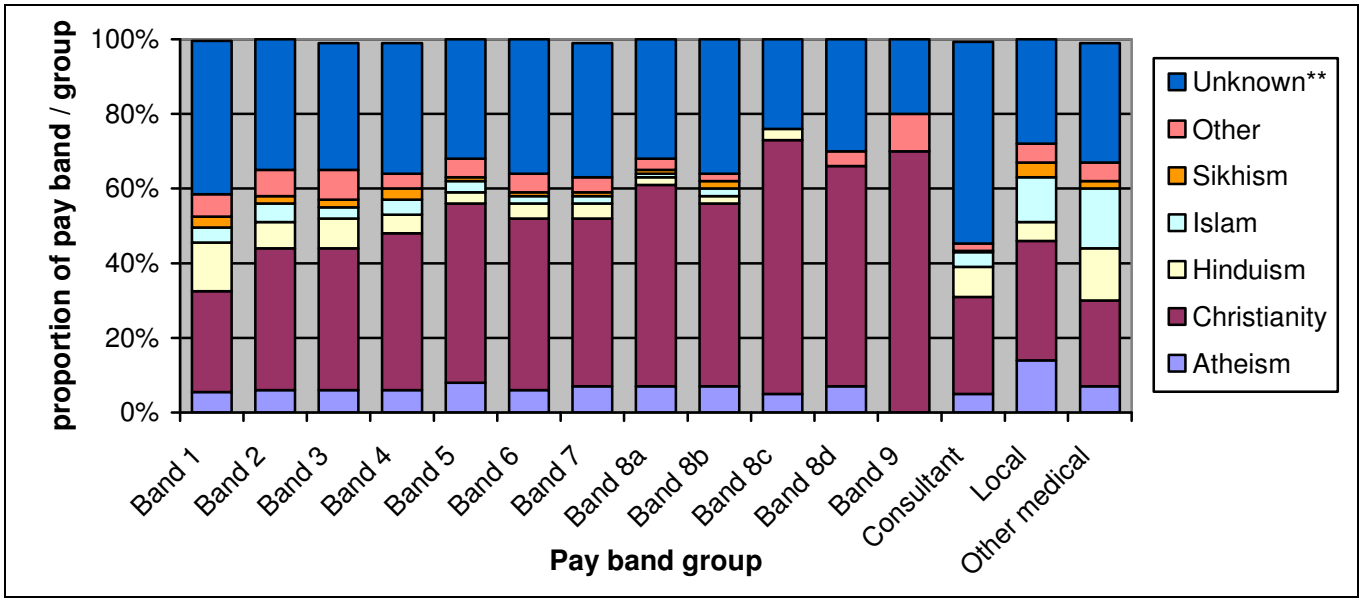
Religion or Belief profile of staff groups.



** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

The data demonstrates that staff with a broad range of beliefs is found within each staff group. Although the overall unknown status is falling it remains above a third in all groups making comparisons with the local population more difficult.

6.2 Religion or Belief and pay

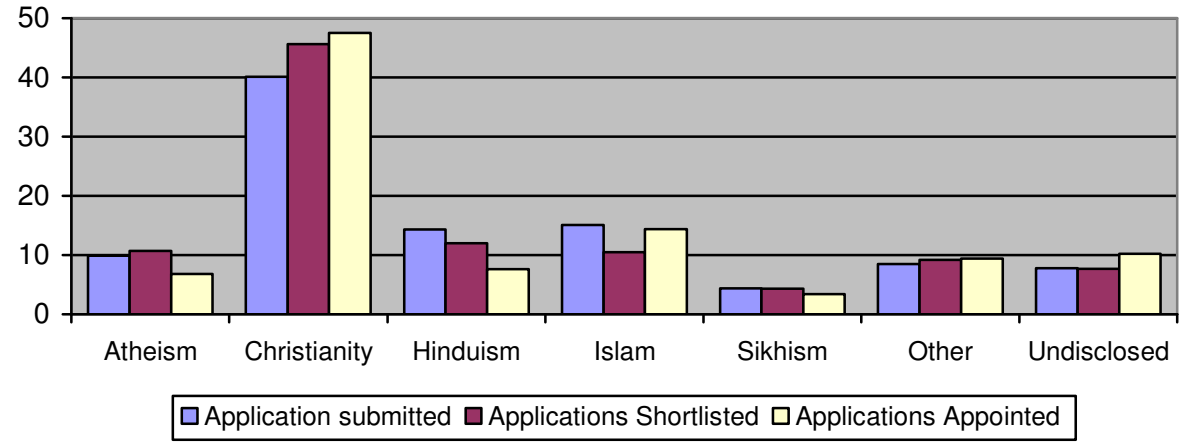


** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

The profile demonstrates that representation changes as pay bands increase, with Christianity becoming more dominant, especially in Bands 8C and above. There appears to be good representation amongst medical staff although over half of consultant data is unknown.

6.3 Religion or Belief Profile at Recruitment

Percentages of applicants' religion or belief at each stage of recruitment process

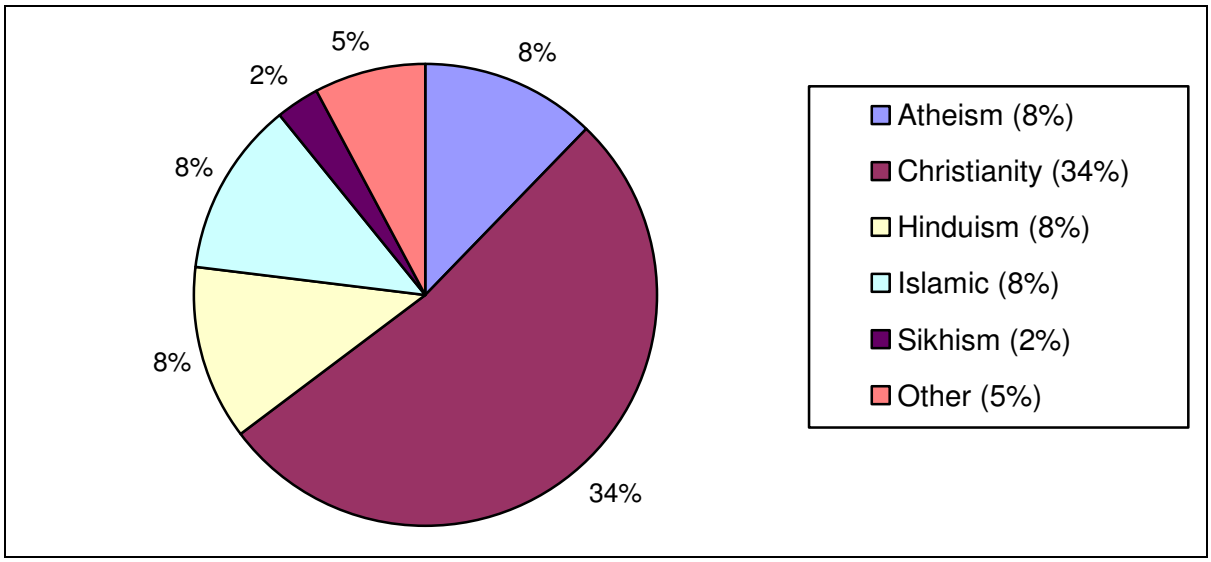


The data shows a different trend for some groups in this year's data. In a reversal from last year which maybe a reflection of the reduction of undisclosed appointees:

- Applicants from a Christian or Islamic faith do better from shortlisting to appointment.
- Applicants who are Atheist fair less well from shortlisting to appointment.

Data from other religious groups remain largely unchanged.

6.4 Religion or belief of staff leaving



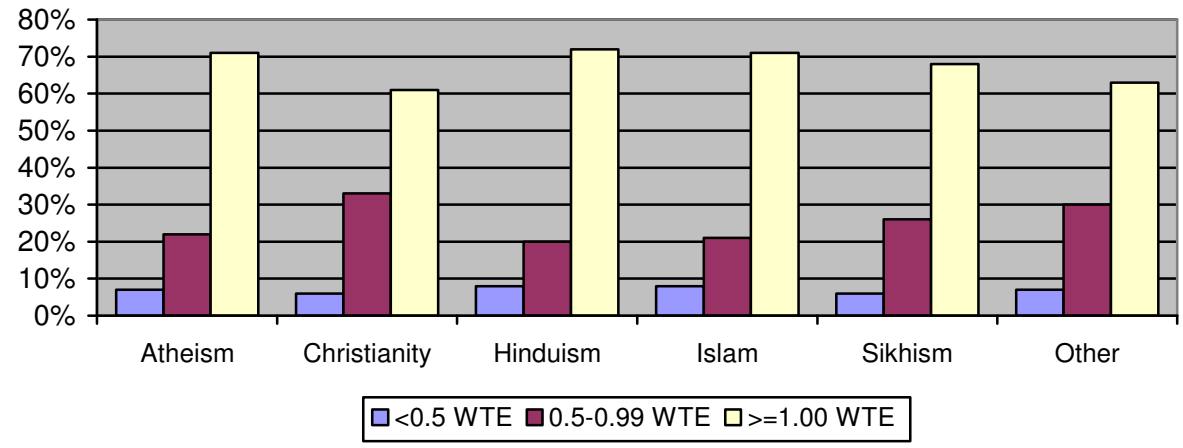
** In this instance unknown included both staff who does not wish to declare their religion/belief (17%) and those who have an undefined status (18%).

Due to the decrease in the unknown status of staff we have seen an increase in all groups with the exception of Sikhism. On further investigation of the data a higher

percentage of Atheists, Christians, Sikhs and those in the 'other' groups leave due to a voluntary resignation reason. For those of a Hindu or Islamic faith the highest percentages are seen in the 'end of fixed term contracts' categories.

6.6 Working patterns

Percentages of working hours by religion or belief.



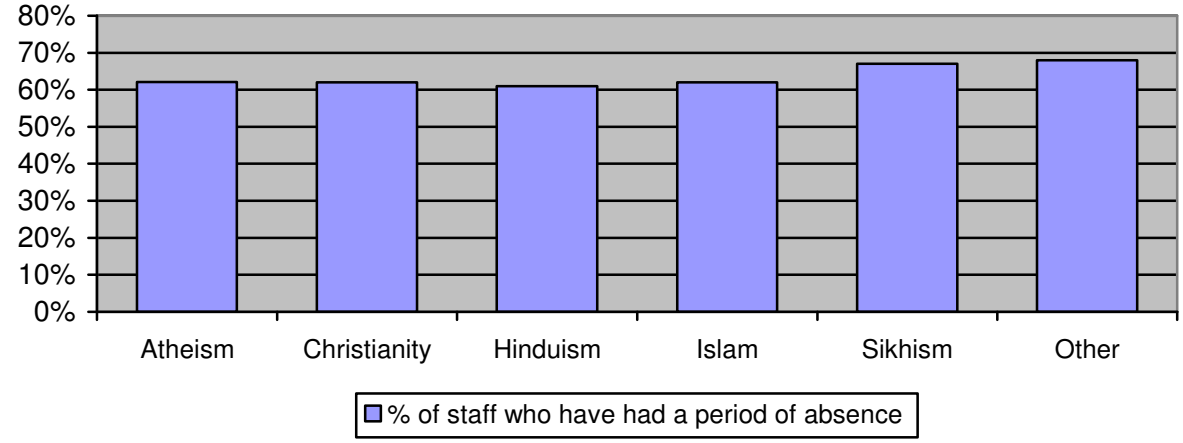
** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

The data demonstrates that flexible hours are worked by all religion or belief groups.

- >70% of staff who are Atheist or those following a Hindu or Islamic faith work full time.
- A higher percentage of staff from a Christian background work between 0.5-0.99WTE.
- In all groups <10% of staff work less that half time.

6.7 Sickness and Absence

Percentages of Absence by Religion or Belief.



The percentages of staff sickness across the religious and belief groups are between 61% - 68%. The lowest is seen amongst staff with a Hindu faith and the highest in those who fall within the 'other' group. There is, however, very little overall difference.

6.8 Disciplinary and Grievance

A total number of 179 disciplinary cases and 12 grievances were concluded during 2013-2014.

Religion or Belief	Total / %	
Atheism	9	5%
Christianity	62	35%
Hinduism	7	4%
Islam	6	3%
Sikhism	2	1%
Other	12	7%
Unknown **	81	45%

From the total data reported on Disciplinary outcomes no religious/ belief group appears to be disproportionately represented. It should be noted however that we only know staff's religion or belief in 45% of cases.
As the total number of grievances are so small (12), no trends are able to be identified.

6.9 Religion or Belief and Access to Training

Religion or Belief	**Training**					
	Leadership (ELMA)		Leadership (UHL)		Day Courses	
Atheism	4	6%	7	11%	54	6%
Christianity	21	29%	29	47%	333	37%
Hinduism	-	-	2	3%	37	4%
Islam	-	-	2	3%	26	3%
Sikhism	-	-	-	-	5	0.5%
Other	3	4%	7	11%	2	0.2%
Unknown **	44	61%	15	24%	450	50%

*This data is not currently collected for apprentices or staff undertaking QFC's.

** Unknown included both staff who does not wish to declare their religion/belief and those who have an undefined status.

Summary

The data indicates an increase known status amongst staff which has resulted in a rise in our representation across most religion and beliefs within the workforce as a whole.

The detailed data demonstrates:

- There is representation of all religions and beliefs across all staff groups, however, there remains unknown status for at least 30% in all.
- Through the recruitment process applicants who are atheist or follow the Hindu, Sikh religion appear to fair less well particularly from shortlisting to appointment.

- There is an over representation of staff from who are atheist or follow the Hindu or Islamic religion leaving the Trust. For the latter groups much maybe explained due to rotation of Medical staff.
- During the disciplinary process no religious/ belief group appears to be disproportionately represented

Key Actions – Points to consider

- No specific action required.

The following three sections are additions under the Equality act (2010) and minimal data is currently collected. A decision needs to be made as to what data we need to collect in the future.

Section 7 – Marriage and Civil Partnership

7.1 Marital status of staff in post.

	March 2014	March 2013
Civil Partnership	0.4%	0.3%
Divorced	5.4%	5.5%
Legally Separated	1.2%	1.3%
Married	57%	58%
Single	31.3%	30%
Widowed	0.7%	0.7%
Unknown	4%	4.3%

Section 8 – Pregnancy & Maternity

8.1 Maternity Leave of Staff in Post.

	Number of staff	Total of days taken
Maternity leave	654	102,425
Paternity leave	89	1,345
Adoption leave	8	1,018

In last years report only maternity figures we reported. The data indicates that 27 less staff took maternity leave this year.

Section 9 – Gender Reassignment.

Data is recorded in this area but not reported due to low numbers with the possibility of breach of confidentiality.

Summary

Little data is currently collected on these three elements

Key Actions

- To decide what information around these three areas needs to be reported.
- To establish appropriate data sets and methods for collection.

Top Priorities for 2015- 2016

- To establish the Ageing workforce task and finish Group.
- To work with the Learning and Organisational Development Team look at access routes for leadership, mentoring and management courses for females, BME and staff with disabilities.
- To review the disciplinary cases involving disabled staff to ensure equity in respect of the process.
- To examine career progression within Consultant and Allied Health Care Professionals

Conclusion

The total head count of staff remains comparatively stable with minimal changes in the equality profile across the organisation. We have continued to see an improvement in staff monitoring data, resulting in an increase in the number of areas we can report on.

Comparing the data to previous years it is evident that each year we see slightly different interesting anomalies between groups in different areas, however there are also key areas we are seeing year on year. This includes the challenge of representation at senior level. This in turn maybe linked to the under representation of some groups within our leadership programmes. As this is a National focus further guidance as to additional work streams may be identified as the year progresses.

The challenge for any organisation wanting to ensure it is fair will be to produce a best fit for the majority of staff while at the same time still meeting individual needs. In order to achieve this continuing to identify areas that would benefit from further analysis thereby providing a deeper understanding is essential.

University Hospitals of Leicester NHS Trust

Workforce Equality programme for 2015- 2016

Equality Delivery System Objective	Action	Lead	By When	Progress Update	RAG status*
To ensure a fair and representative workforce at all levels of the Trust :	To include unconscious bias training in the Recruitment and Selection and Corporate Equality training.	**Equality and Recruitment**	**April 2015**	Meeting to be arranged with Recruitment Services Manager by end of January	**1**
	To implement the national Workforce Equality Standard	**Equality Lead**	**April 2015**	Awaiting confirmation of standard from Department of Health	**1**
	To undertake an annual review of the Disciplinary and Grievance access to ensure that where a group is disproportionately represented the process has been applied fairly.	**Equality Lead**	**May 2015**	Case Review to be undertaken with HR Team	**1**
	To ensure that there is no adverse equality impact following the implementation of the Pay Progression Policy.	**Human Resources Policy Lead**	**July 2015**	An initial Due Regard analysis has been completed that recommends ongoing monitoring by protected group to ensure equitable application.	**4**
	To ensure training and development opportunities are accessed fairly across the Trust.	**Learning and organisational Development Team**	**March 2015**	Access to training is reported in the annual workforce report. Further analysis to be undertaken to look at increasing access for BME staff and to be reported to the Training & Education in March 2015.	**4**
	To analyse, report and action the results of the Friends and Family test by all of the protected groups. Staff from Protected Groups report positive experiences of their membership of the workforce.	**Equality and Listening into Action Lead**	**April 2015**	Q1 and 2 have been analysed by Protected Group and will be presented to The Executive Workforce Board in March 2015 with Q3's results included.	**4**

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Appendix 2

Equality Delivery System Objective	Action	Lead	By When	Progress Update	RAG status*
	To ensure that the next National Staff Survey is reported by protected group to ensure the level of satisfaction is broadly similar across all Protected Groups.	**Workforce Development Manager**	**November 2015**	To discuss with survey provider at commissioning stage.	**1**
	To see a further increase in the number of BME staff at band 7 appointments.	**Equality Lead**	**December 2015**	Currently stands at 18%.To support through related actions including access to mentoring, leadership courses.	**1**
	To see a further increase in the number of female Consultant appointments.	**Medical Director**	**December 2015**	Currently stands at 29.4% .To support through related actions including access to mentoring, leadership courses.	**1**
	Report the findings of the UHL Equality Survey conducted in November 2014.	**Equality Lead**	**January 2014**	To present the findings and recommendations to the Executive Workforce Board March 2015. To include any identified actions in the work programme for this year	**4**
	To increase by 10% the employee equality information held across all of the protected characteristics of by undertaking a revalidation of all employee personal details.	**Payroll Team**	**March 2015**	Revalidation with robust communication/messaging to be undertaken.	**1**
	Re apply for the Mental Health Pledge , Public Health Responsibility Deal.	**Occupational Health Lead**	**April 2015**	Application to be completed.	**4**
Inclusive leadership	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Trust Board**	**Ongoing**	All equality impacts are recorded on the Board paper cover sheet. Any adverse impacts are documented and discussed.	**5**
	Line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Clinical Management Patient Experience and Equality Leads**	**Ongoing**	A new training programme has been developed entitled ''nipping it in the bud'' to deliver a pilot session March 2015.	**4**

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

Appendix 2

Equality Delivery System Objective	Action	Lead	By When	Progress Update	RAG status*
	To implement a more robust mentoring system taking particular account of our female and BME talent pipeline.	**Learning and Organisational Development Team**	**July 2015**	A task and finish group is due to meet in January.	**4**
	Ensure our workforce related policies and procedures continue to promote equality and diversity	**Equality Team**	**Ongoing**	The Equality Manager reviews all Policies as part of attendance at the Policy and Guidelines Committee	**4**
	Aim to increase the number of job outcomes for our Leicester Works Students by 10%	**Equality Team**		New cohort of students started at UHL in September 2014 and support being provided for selection processes	**4**
	To ensure that proactive planning is in place for areas where there is an ageing workforce	**Equality Team/CMG HR Lead**	**June 2015**	A task and finish group to meet early February 2015.	**4**

** Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.*

RAG Status Key:	***5***	***Complete***	***4***	***On Track***	***3***	***Some Delay – expected to be completed as planned***	***2***	***Significant Delay – unlikely to be completed as planned***	***1***	***Not yet commenced***

University Hospitals of Leicester NHS
NHS Trust

Agenda Item: Trust Board Paper I

TRUST BOARD – 8th JANUARY 2015

UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK 2014/15

DIRECTOR:	RACHEL OVERFIELD – CHIEF NURSE
AUTHOR:	PETER CLEAVER – RISK AND ASSURANCE MANAGER
DATE:	8TH JANUARY 2015
PURPOSE:	This report provides the Trust Board (TB) with:- a) A copy of the UHL BAF and action tracker as of 30th November 2014. b) Notification of any new extreme or high risks opened during November 2014. Taking into account the contents of this report and its appendices the TB is invited to: (a) review and comment upon this iteration of the BAF, as it deems appropriate: (b) note the actions identified within the framework to address any gaps in either controls or assurances (or both); (c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives; (d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained; (e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives; (f) Consider and advise the UHL Risk and Assurance Manager, in relation to sections 2.2 (a), (b) and (e) of this report. (g) Note the newly opened extreme and high operational risks listed in section 3.2 and at appendix three.
PREVIOUSLY CONSIDERED BY:	
Objective(s) to which issue relates *	[x] 1. Safe, high quality, patient-centred healthcare [x] 2. An effective, joined up emergency care system [x] 3. Responsive services which people choose to use (secondary, specialised and tertiary care) [x] 4. Integrated care in partnership with others (secondary, specialised and

	☑ tertiary care) ☑ 5. Enhanced reputation in research, innovation and clinical education ☑ 6. Delivering services through a caring, professional, passionate and valued workforce ☑ 7. A clinically and financially sustainable NHS Foundation Trust ☑ 8. Enabled by excellent IM&T
Please explain any Patient and Public Involvement actions taken or to be taken in relation to this matter:	N/A
Please explain the results of any Equality Impact assessment undertaken in relation to this matter:	N/A
Strategic Risk Register/ Board Assurance Framework *	☐ **Organisational Risk Register** ☑ **Board Assurance Framework** ☐ **Not Featured**
ACTION REQUIRED *	For decision ☑ For assurance ☑ For information ☐

♦ We treat people how we would like to be treated ♦ We do what we say we are going to do
♦ We focus on what matters most ♦ We are one team and we are best when we work together
♦ We are passionate and creative in our work

***** tick applicable box

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **8th JANUARY 2015**

REPORT BY: **RACHEL OVERFIELD – CHIEF NURSE**

SUBJECT: **UHL RISK REPORT INCORPORATING THE BOARD ASSURANCE FRAMEWORK (BAF) 2014/15**

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1. INTRODUCTION

1.1 This report provides the Trust Board (TB) with:-

a) A copy of the UHL BAF and action tracker as of 30th November 2014.

b) Notification of any new extreme or high risks opened during November 2014

2. BAF POSITION AS OF 30th NOVEMBER 2014

2.1 A copy of the 2014/15 BAF is attached at appendix one with changes since the previous version highlighted in red text. A copy of the BAF action tracker is attached at appendix two.

2.2 In relation to the regular BAF report for the period ending 30th November 2014, the TB is asked to note the following points:

a. The Trust has declared seven Internal Major Incidents (IMI) since 1 November 2014 due to increased inflow and ED activity; increased emergency admissions; severe capacity problems, and inability to discharge sufficient numbers of patients back into the community.

   This has resulted in extreme pressures within UHL including long waiting times in ED and slow outflow from the department; the need to open additional capacity; severe staffing pressures, both nursing and medical workforce, and suboptimal quality of care including patient harm.

   In light of the above the current risk score assigned to principal risk 2 (failure to implement LLR emergency care improvement plan) has been increased to 20 (i.e. likelihood score increased from 4 to 5). The Chief Operating Officer, Chief Nurse and Director of Safety and Risk shall consider whether a specific risk in relation to patient harm due the current difficulties in achieving this objective should be entered on the organisational risk register.

b. Principal risks 1 and 11 have no gaps in control or assurance identified and the TB is asked to consider revising the current risk scores to the level of the target risk scores unless further gaps and actions are identified.

c. Principal risk 12 has an elevated current risk score (previously 6, now 9) due to the requirement to replace senior staff and increase critical mass of senior academic staff in each Biomedical Research Unit (BRU). In

addition there is a need to achieve Athena Swan Silver in order to become eligible for NIHR awards.

d. Principal risk 14 has an elevated current risk score (previously 6, now 9) reflecting the need for effective relationships to be developed with the new Vice Chair and President and Dean of new medical school.

e. Principal risk 24 has achieved its target score and the TB is asked to consider and advise whether this risk should be closed.

f. A number of updates to actions were not available at time of writing and therefore both the Director of Finance (DF) and the Director of Marketing and Communications (DMC) are asked to provide verbal updates, if required, to the TB in relation to the actions in the table below.

Action No.	Executive Lead	Date for completion
6.3	DMC	November 2014
19.5	DF	October 2014
19.6	DF	October 2014
19.8	DF	October 2014
19.11	DF	October 2014

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2.3 It has previously been agreed that the monthly TB review of the BAF be structured so as to include all the principal risks relating to an individual strategic objective. The following objective is therefore submitted to this TB for discussion and review:

'Delivering services through a caring, professional passionate and valued workforce (incorporating principal risks 15, 16 and 17).

3. EXTREME AND HIGH RISK REGISTER REPORT.

3.1 To assist the TB in maintaining awareness of current operational risks scoring 15 or above (i.e. 'high' or 'extreme' risks), the TB is asked to note that one new high risk has opened during November 2014, as described in the table below. A full description of this risk is included at appendix three, for information.

Risk ID	Risk Title	Risk Score	CMG/ Directorate
2445	SpR gaps on the ESM CMG Medical Rota	20	ESM

3.2 By way of an update, the TB is asked to note that during December 2014, a new extreme risk (scoring 25) has opened relating to concerns that the bed base over the winter months will be insufficient to deal with the number of medical admissions resulting in the need to out lie into other speciality/CMG beds jeopardizing delivery of the RTT targets.

4. RECOMMENDATIONS

4.1 Taking into account the contents of this report and its appendices the TB is invited to:

(a) review and comment upon this iteration of the BAF, as it deems appropriate:

(b) note the actions identified within the framework to address any gaps in either controls or assurances (or both);

(c) identify any areas which it feels that the Trust's controls are inadequate and do not, therefore, effectively manage the principal risks to the organisation achieving its objectives;

(d) identify any gaps in assurances about the effectiveness of the controls in place to manage the principal risks and consider the nature of, and timescale for, any further assurances to be obtained;

(e) identify any other actions which it feels need to be taken to address any 'significant control issues' to provide assurance on the Trust meeting its principal objectives;

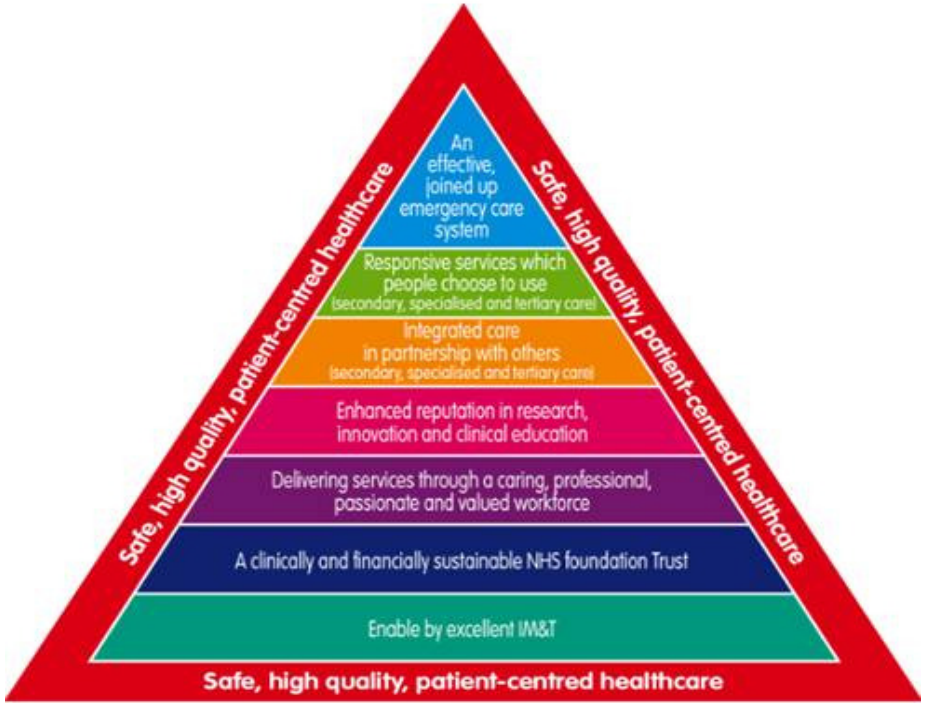
(f) Consider and advise the UHL Risk and Assurance Manager, in relation to sections 2.2 (b) and (e) of this report.

(g) Note the newly opened extreme and high operational risks listed in section 3.2 and at appendix three.

Peter Cleaver,
Risk and Assurance Manager,
30th December 2014.

Appendix 1

UHL BOARD ASSURANCE FRAMEWORK 2014/15



UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

STRATEGIC OBJECTIVES

Objective	Description	Objective Owner(s)
a	Safe, high quality, patient centred healthcare	Chief Nurse
b	An effective, joined up emergency care system	Chief Operating Officer
c	Responsive services which people choose to use (secondary, specialised and tertiary care)	Director of Strategy / Chief Operating Officer/ Director of Marketing &Communications
d	Integrated care in partnership with others(secondary, specialised and tertiary care)	Director of Strategy
e	Enhanced reputation in research, innovation and clinical education	Medical Director
f	Delivering services through a caring, professional, passionate and valued workforce	Director of Human Resources
g	A clinically and financially sustainable NHS Foundation Trust	Director of Finance
h	Enabled by excellent IM&T	Chief Executive / Chief Information Officer

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

PERIOD:NOVEMBER 2014

Risk No.	Link to objective	Risk Description	Risk owner	Current Score	Target Score
1.	Safe, high quality, patient centred healthcare	Lack of progress in implementing UHL Quality Commitment.	CN	12	8
2.	An effective joined up emergency care system	Failure to implement LLR emergency care improvement plan.	COO	20	6
3.		Failure to effectively implement UHL Emergency Care quality programme	COO	16	6
4.		Delay in the approval of the Emergency Floor Business Case.	MD	12	6
5.	Responsive services which people choose to use (secondary, specialised and tertiary care)	Failure to deliver RTT improvement plan.	COO	9	6
6.		Failure to achieve effective patient and public involvement	DMC	12	8
7.		Failure to effectively implement Better Care together (BCT) strategy.	DS	12	8
8.		Failure to respond appropriately to specialised service specification.	DS	15	8
	Integrated care in partnership with others (secondary, specialised and tertiary care)	Failure to effectively implement Better Care together (BCT) strategy.**(See 7 above)**	DS		
9.		Failure to implement network arrangements with partners.	DS	8	6
10.		Failure to develop effective partnership with primary care and LPT.	DS	12	8
11.	Enhanced reputation in research, innovation and clinical education	Failure to meet NIHR performance targets.	MD	6	6
12.		Failure to retain BRU status.	MD	9	6
13.		Failure to provide consistently high standards of medical education.	MD	9	4
14.		Lack of effective partnerships with universities.	MD	9	6
15.	Delivering services through a caring, professional, passionate and valued workforce	Failure to adequately plan workforce needs of the Trust.	DHR	12	8
16.		Inability to recruit and retain staff with appropriate skills.	DHR	12	8
17.		Failure to improve levels of staff engagement.	DHR	9	6
18	A clinically and financially sustainable NHS Foundation Trust	Lack of effective leadership capacity and capability	DHR	9	6
19		Failure to deliver the financial strategy (including CIP).	DF	15	10
20		Failure to deliver internal efficiency and productivity improvements.	COO	16	6
21.		Failure to maintain effective relationships with key stakeholders	DMC	15	10

22.		Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	DS	10	5
23.	Enabled by excellent IM&T	Failure to effectively implement EPR programme.	CIO	15	9
24.		Failure to implement the IM&T strategy and key projects effectively	CIO	9	9

BAF Consequence and Likelihood Descriptors:

Impact/Consequence			**Likelihood**	
5	Extreme	Catastrophic effect upon the objective, making it unachievable	5	Almost Certain (81%+)
4	Major	Significant effect upon the objective, thus making it extremely difficult/ costly to achieve	4	Likely (61% - 80%)
3	Moderate	Evident and material effect upon the objective, thus making it achievable only with some moderate difficulty/cost.	3	Possible (41% - 60%)
2	Minor	Small, but noticeable effect upon the objective, thus making it achievable with some minor difficulty/ cost.	2	Unlikely (20% - 40%)
1	Insignificant	Negligible effect upon the achievement of the objective.	1	Rare (Less than 20%)

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 1	Lack of progress in implementing UHL Quality Commitment.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Chief Nurse			
Link to strategic objectives	Provide safe, high quality, patient centred healthcare			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Corporate leads agreed for each goal and identified leads for each work stream of the Quality Commitment.	Q&P Report. Reports to EQB and QAC.			
KPIs agreed for all parts of the Quality Commitment.	Reports to EQB and QAC based on key outcome/KPIs.	No gaps identified		
Clear work plans agreed for all parts of the Quality Commitment.	Action plans reviewed regularly at EQB and annually reported to QAC. Annual reports produced. Summary report scheduled for EQB February 2015	No gaps identified		
Committee structure is in place to oversee delivery of key work streams – led by appropriate senior individuals with appropriate support.	Regular committee reports. Annual reports. Achievement of KPIs.	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 2	Failure to implement LLR emergency care improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score** 4 x 5 = 20	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Establishment of emergency care delivery and improvement group with named sub groups	Meetings are minuted with actions circulated each week. Trust Board emergency care report references the LLR steering group actions.	(C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (2.4)	LLR MD review Dec 2014
Appointment of Dr Ian Sturgess to work across the health economy	Weekly meetings between Dr Sturgess, UHL CEO and UHL COO. Dr Sturgess attends Trust Board.	(C) IS's time with the health economy finishes in mid-November 2014	Arrangements for IS to return for a two week period in January 2015 (2.5)	Jan 2015 RM
Allocation of winter monies	Allocation of winter monies is regularly discussed in the LLR steering group	None	N/A	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 3	Failure to effectively implement UHL Emergency Care quality programme.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Emergency care action team meeting has been remodelled as the 'emergency quality steering group' (EQSG) chaired by CEO and significant clinical presence in the group. Four sub groups are chaired by three senior consultants and chief nurse.	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges (3.1)	Feb 2015 COO
Reworked emergency plans are focussing on the new dashboard with clear KPIs which indicates which actions are working and which aren't	Dashboard goes to EQSG and Trust Board	(C) ED performance against national standards	As 3.1	Feb 2015 COO
Further change leadership support has been identified to help embed the required clinically led changes	Trust Board are sighted on actions and plans coming out of the EQSG meeting.	C) Emergency admissions are not reducing (C) Discharges are not increasing and delayed discharge rate has not changed	As 3.1	Feb 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 4	Delay in the approval of the Emergency Floor Business Case.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	An effective joined up emergency care system			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Monthly ED project program board to ensure submission to NTDA as required Gateway review process Engagement with stakeholders	Monthly reports to Executive Team and Trust Board Gateway review	(c) Inability to control NTDA internal approval processes	Regular communication with NTDA (4.1)	On-going action to complete in Mar 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 5	Failure to deliver RTT improvement plan.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Weekly RTT meeting with commissioners to monitor overall compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	Action plans to be developed in key specialities to regain trajectory (5.1)	Dec 2014 COO
Weekly meeting with key specialities to monitor detailed compliance with plan	Trust Board receives a monthly report detailing performance against plan	(c) UHL is behind trajectory on its admitted RTT plan	As above 5.1	Dec2014 COO
Intensive support team back in at UHL (July 2014) to help check plan is correct	IST report including recommendations to be presented to Trust Board	(c) recommendations from IST report not yet implemented.	Act on findings from recently published IST report (5.2)	Mar 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 6	Failure to achieve effective patient and public involvement	**Overall level of risk to the achievement of the objective**	**Current score 4x3=12**	**Target score 4x2=8**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
1. PPI / stakeholder engagement Strategy Named PPI leads in all CMGs 2. PPI reference group meets regularly to assess progress against CMG PPI plans 3. Patient Advisors appointed to CMGs 4. Patient Advisor Support Group Meetings receive regular updates on PPI activity and advisor involvement 5. Bi-monthly Membership Engagement Forums 6. Health watch representative at UHL Board meeting 7. PPI input into recruitment of Chair / Exec' Directors 8. Quarterly meetings with LLR Health watch organisations, including Q's from public. 9. Quarterly meetings with Leicester Mercury Patient Panel	Emergency floor business case (Chapel PPI activity) PPI Reference group reports to QAC July Board Development session discussion about PPI resource. Health watch updates to the Board Patient Advisor Support Group and Membership Forum minutes to the Board.	PPI/ stakeholder engagement strategy requires revision Time available for CMG leads to devote to PPI activity Incomplete PPI plans in some CMGs PA vacancies (4) Single handed PPI resource corporately	Update the PPI/stakeholder engagement strategy (6.1) OD team involvement to reenergise the vision and purpose of Patient Advisors (6.3)	Dec 2014 DMC Nov 14 DMC

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 7	Failure to effectively implement Better Care together (BCT) strategy.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Better Care Together (BCT) Strategy: • UHL actively engaged in the Better Care Together governance structure, from an operational to strategic level • Better Care Together plans co–created in partnership with LLR partners • Final approval of the 5 year strategic plan, Programme Initiation Document (PID – 'mobilises' the Programme) and SOC to be made at the Partnership Board of 20th November 2014 • Better Care Together planning assumptions embedded in the Trust's 2015/16 planning round	• BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads) • Workbooks for all 8 clinical work streams and 4 enabling groups • Feedback from September 2014 Delivery Board and Clinical Reference Group workshops • LLR BCT refreshed 5 year strategic plan approved by the BCT Partnership Board • Minutes and Action Log from the BCT Programme Board	(a) Final approval of the strategic plan, PID and SOC	BCT SOC to be presented at the December 2014 Trust Board meeting for approval	Dec 2014
Effective partnerships with primary care and Leicestershire Partnership Trust (LPT): 1) Active engagement and leadership of the LLR Elective Care Alliance 2) LLR Urgent Care and Planned Care work streams in partnership with local GPs 3) A joint project has been established to test the concept of early transfer of sub-acute care to a community hospitals setting or home in partnership with LPT. The impact of this is reflected in UHLs, LPTs the LLR BCT 5 year plans 4) Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan 5) Active engagement in the BCT LTC work stream. Mutual accountability for the delivery of shared objectives are reflected in the LLR BCT 5 year directional plan	• Minutes of the June public Trust Board meeting: o Trust Board approved the LLR BCT 5 year directional plan and UHLs 5 year directional plan on 16 June, 2014 o Urgent care and planned care work streams reflected in both of these plans • BCT resource plan, identifying all work books named leads (SRO, Implementation leads and clinical leads agreed at the BCT Partnership Board (formerly the BCT Programme Board) meeting held on 21st August 2014 Workbooks for all 8 clinical work streams and 4 enabling groups underway – progress overseen by implementation	(a) Final approval of the strategic plan, PID and SOC	See action 7.4	Dec 2014

	group and the Strategy Delivery Group which reports to BCT Partnership Board.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 8	Failure to respond appropriately to specialised service specification.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Responsive services which people choose to use (secondary, specialised and tertiary care) Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
(i) Regional partnerships: UHL is actively engaging with partners with a view to: • establishing a Leicestershire Northamptonshire and Rutland partnership for the specialised service infrastructure in partnership with Northampton General Hospital and Kettering General Hospital • establishing a provider collaboration across the East Midland's as a whole • Developing an engagement strategy for the delivery of the long term vision for and East Midlands network for both acute and specialised services	Minutes of the April 2014 Trust Board meeting: o Paper presented to the April 2014 UHL Trust Board meeting, setting out the Trust's approach to regional partnerships Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the June 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of Programme Plan	Programme Plan to be developed (8.3)	Apr 2015 DS
(ii) Academic and commercial partnerships. (iii) Local partnerships	Project Initiation Document (PID): o Developed as part of UHL's Delivering Care at its Best (DC@IB) o Reviewed at the August 2014 Executive Strategy Board (ESB) meeting o Updates (DC@IB Highlight Report reviewed at ESB meetings	(c) Lack of PID for local partnerships	PID for Local Partnerships to be developed by the Head of Local Partnerships (8.7)	Dec 2014 DS
Specialised Services specifications: CMGs addressing Specialised Service derogation plans	Plans issued to CMGs in February 2014. Follow up meetings being convened for w/c 14th July 2014to identify progress to date.			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 9	Failure to implement network arrangements with partners.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 2 = 8**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Regional partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Academic and commercial partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Local partnerships	See risk 8	See risk 8	See risk 8	See risk 8
Delivery of Better Care Together:	See risk 7	See risk 7	See risk 7	See risk 7

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 10	Failure to develop effective partnership with primary care and LPT.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	Integrated care in partnership with others (secondary, specialised and tertiary care)			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Effective partnerships with LPT	See risk 7	See risk 7 for other gaps	See risk 7 for other actions	
Effective partnerships with primary care	See risk 7			

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 11	Failure to meet NIHR performance targets.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 2 = 6**	**Target score 3 x 2= 6**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Action Plan developed in response to the introduction of national metrics and potential for financial sanctions	Performance in Initiation & Delivery of Clinical Research (PID) reports from NIHR – to CE and R&D (quarterly) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly) R&D working with CMG Research Leads to educate and embed understanding of targets across CMGs (regular; as required)	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 12	Failure to retain BRU status.	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 3= 9	**Target score** 3 x 2 = 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key partners to support joint NIHR/ BRU infrastructure	Joint BRU Board (bimonthly) Annual Report Feedback from NIHR for each BRU (annual) UHL R&D Executive (monthly) R&D Report to Trust Board (quarterly)	(c) Requirement to replace senior staff and increase critical mass of senior academic staff in each of the three BRUs.	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1) BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages. (12.2) UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU. (12.3)	Jun 2015 MD June 2015 MD Jun 2015 MD
	Athena Swan Silver Status by University of Leicester and Loughborough University. (The Athena Swan charter applies to higher	(c) Athena Swan Silver not yet achieved byUoL and Loughborough	UoL and LU to ensure successful applications for	Mar2016 MD

	education institutions)	University. This will be required for eligibility for NIHR awards	Silver swan status and. Individual medical school depts will need to separately apply for AthenaSwan Silver status. (12.4) Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned. (12.5)	 Mar 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 13	Failure to provide consistently high standards of medical education.	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 2 x 2 = 4**
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Medical Education Strategy	Department of Clinical Education (DCE) Business Plan and risk register are discussed at regular DCE Team Meetings and information given to the Trust Board quarterly Medical Education issues championed by Trust Chairman Bi-monthly UHL Medical Education Committee meetings (including CMG representation) Oversight by Executive Workforce Board Appointment processes for educational roles established KPI are measured using the: • UHL Education Quality Dashboard • CMG Education Leads and stakeholder meetings • GMC Trainee Survey results • UHL trainee survey • Health Education East Midlands Accreditation visits	(c) Transparent and accountable management of postgraduate medical training tariff is not yet established (c) Transparent and accountable management of SIFT funding not yet identified in CMGs (proposal prepared for EWB) (c) Job Planning for Level 2 (SPA) Educational Roles not written into job descriptions (c) Appraisal not performed for Educational Roles	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs (13.1) Ensure appropriate Consultant Job descriptions include job planning (13.2) Develop appraisal methodology for educational roles (13.3) Disseminate agreed	Jan 2015 MD Jan 2015 MD Jan 2015 MD Feb 2015

			appraisal methodology to CMG s (13.4)	MD
		Trainee Drs in community – anomalous location in DCE budgets	Work to relocate anomalous budgets to HR as other Foundation doctor contracts (13.5)	Apr 2015 MD
UHL Education Committee	CMG Education Leads sit on Committee. Education Committee delivers to the Workforce Board twice monthly and Prof. Carr presents to the Trust Board Quarterly.	No system of appointing to College Tutor Roles	Develop more robust system of appointment and appraisal of disparate roles by separating College Tutor roles in order to be able to appoint and appraise as College Tutors	Jan 2015 MD

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 14	Lack of effective partnerships with universities.	**Overall level of risk to the achievement of the objective**	**Current score** 3 x 3=9	**Target score** 3 x 2= 6
Executive Risk Lead(s)	Medical Director			
Link to strategic objectives	Enhanced reputation in research, innovation and clinical education			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Maintaining relationships with key academic partners Developing relationships with key academic partners. Existing well established partners: • University of Leicester • Loughborough University	Minutes of joint UHL/UoL Strategy meetings Minutes of Joint BRU Board Minutes of NCSEM Management Board	(c) New relationships need to be developed and nurtured with the new VC and President for UHL. New Dean of Medical School expected 2015.	UHL CE to meet with VC in near future. (14.1) LU strategy to be discussed at joint BRU board. (14.2) UHL membership of NCSEM management board (14.3) Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy (14.4)	Mar 2015 CEO Mar 2015 Mar 2015 Jun 2015
Developing partnerships; • De Montfort University • University of Nottingham • University College London (Life Study) • Cambridge University (100k project)	100k genome and Life study reports to ESB monthly. Joint meetings held with R&D team for NUH - reported through R&D Exec minutes to ESB. EM CLAHRC Management Board reports via R&D Exec to ESB	(c) Contacts with DMU could be developed more closely	Develop regular meeting with DMU (14.5)	Jun 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 15	Failure to adequately plan the workforce needs of the Trust.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
UHL Workforce Plan (by staff group) includingan integrated approach to workforce planning with LPT.	Reduction in number of 'hotspots' for staff shortages across UHL reported as part of workforce plan update. Executive Workforce Board will consider progress in relation to the overarching workforce plan through highlight report from CMG action plans.	(c) Workforce planning difficult to forecast more than a year ahead as changes are often dependent on transformation activities outside UHL (e.g. social services/ community services and primary care and broad based planning assumptions around demographics and activity). (c) Difficulty in recruiting to hotspots as frequently reflect a national shortage occupation (e.g. nurses)	Develop Innovative approaches to recruitment and retention to address shortages. (15.4)	Mar 2015 DHR
Nursing Recruitment Trajectory and international recruitment plan in place for nursing staff	Overall nursing vacancies are monitored and reported monthly by the Board and NET as part of the Quality and Performance Report NHS Choices will be publishing the planned and actual number of nurses on each shift on every			

	inpatient ward in England			
Development of an Employer Brand and Improved Recruitment Processes	Reports of the LIA recruitment project Reports to Executive Workforce Board regarding innovative approaches to recruitment	(c) Capacity to develop and build employer brand marketing (c) capacity to build innovative approaches to consultant recruitment	Deliverour Employer Brand group to share best practice and develop social media techniques to promote opportunities at UHL (15.6) Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme (15.8)	Mar 2015 DHR April 2015 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 16	Inability to recruit and retain staff with appropriate skills.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 3 = 12**	**Target score 4 x 2 = 8**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Refreshed Organisational Development Plan (2014-16) including five work streams: 'Live our Values' by embedding values in HR processes including values based recruitment, implementing our Reward and Recognition Strategy (2014-16) and continuing to showcase success through Caring at its Best Awards	Quarterly reports to EWB and Trust Board and measured against implementation plan milestones set out in PID	(a) Improvements required in 'measuring how we are doing'	Team Health Dashboard to be developed and implemented (16.1)	Dec2014 DHR
'Improve two-way engagement and empower our people' by implementing the next phase of Listening into Action (see Principal Risk 16), building on medical engagement, experimenting in autonomy incentivisation and shared governance and further developing health and wellbeing and Resilience Programmes.	Quarterly reports to and EWB and measured againstImplementation Plan Milestones set out in PID	No gaps identified		
'Strengthen leadership' by implementing the Trust's Leadership into Action Strategy (2014-16) with particular emphasis on 'Trust Board Effectiveness', 'Technical Skills Development' and 'Partnership Working'	Quarterly reports to EWB and bi-monthly reports to UHL LETG. Measured against implementation Plan milestones set out in PID	No gaps identified		
'Enhance workplace learning' by building on training capacity and resources, improvements in medical education and developing new roles	Quarterly report to EQB, EWB and bi-monthly reports to UHL LETG and LLR WDC. Measured against implementation plan milestones set out in PID	(a) eUHL System requires significant improvement in centrally managing all development activity (c) Robust processes required in relation to e-learning development	eUHL system updates required to meet Trust needs (16.2) Robust ELearningpolicy and procedures to be developed (16.3)	Mar 2015 DHR Jan 2015 DHR
'Quality Improvement and innovation' by implementing quality improvement education, continuing to develop quality improvement	Quarterly reports to EQB and EWB and measured against implementation plan milestones set out in	No gaps identified		

networks and creating a Leicester Improvement and Innovation Centre	PID.			
Appraisal and Objective Setting in line with Strategic Direction	Appraisal rates reported monthly via Quality and Performance Report. Appraisal performance features on CMG/Directorate Board Meetings. Board/CMG Meetings to monitor the implementation of agreed local improvement actions	No gaps identified		

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 17	Failure to improve levels of staff engagement	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	Delivering services through a caring, professional, passionate and valued workforce			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Year 2 Listening into Action (LiA) Plan (2014 to 2015) including five work streams: Work stream One: **Classic LiA** • Two waves of Pioneering teams to commence (with 12 teams per wave) using LiA to address changes at a ward/department/pathway level	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on success measures per team and reports on Pulse Check improvements Annual Pulse Check Survey conducted (next due in Feb 2015) Update reports provided to JSCNC meetings	(a Lack of triangulation of LiA Pulse Check Survey results with National Staff Opinion Survey and Friends and Family Test for Staff	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014 meeting (Please see Principal Risk 15) (17.1)	Mar 2015 DHR
Work stream Two: **Thematic LiA** • Supporting senior leaders to host Thematic LiA activities. These activities will respond to emerging priorities within Executive Directors' portfolios. Each Thematic event will be hosted and led by a member of the Executive Team or delegated lead.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	No gaps identified		
Work stream Three: **Management of Change LiA** • LiA Engagement Events held as a precursor to change projects associated with service transformation and / or HR Management of Change (MoC) initiatives.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(c Reliant on IBM / HR to notify LiA Team of MoC activity	Ensure IBM aware of requirements. (17.2) HR Senior Team aware of need to include Engagement event prior to formal	Mar 2015 DHR Mar 2015 DHR

			consultation (with MoC impacting on staff – (more than 25 people) (17.3)	
Work stream Four: **Enabling LiA** • Provide support to delivering UHL strategic priorities (Caring At its Best), where employee engagement is required.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group on each thematic activity Update reports provided to JSCNC meetings	(C) Resource requirements in terms of people and physical resources difficult to anticipate from LiA activity linked to Caring at its Best engagement events	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required (17.4)	Mar 2015 DHR
Work stream Five: **Nursing into Action (NiA)** • Support all nurse led Wards or Departments to host a listening event aimed at improving quality of care provided to patients and implement any associated actions.	Quarterly reports to Executive Workforce Board (EWB) and Trust Board Updates provided to LiA Sponsor group every 6 months on success measures per set and reports on Pulse Check improvements Update reports provided to JSCNC meetings Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG	No gaps identified		
Annual National Staff Opinion and Attitude Survey	Annual Survey report presented to EWB and Trust Board Analysis of results in comparison to previous year's results and to other similar organisations presented to EWB and Trust Board annually Updates on CMG / Corporate actions taken to address improvements to National Survey presented to EWB Staff sickness levels may also provide an indicator of staff satisfaction and performance and are reported monthly to Board via Quality and Performance report Results of National staff survey and local patient	(a) Lack of triangulation of National Staff Survey results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as Friends and Family Test for Staff	Please see action 17.1	Mar 2015 DHR

	polling reported to Board on a six monthly basis. Improving staff satisfaction position.			
Friends and Family Test for NHS Staff	Quarterly survey results for Quarter 1, 2 and 4 to be submitted to NHS England for external publication: Submission commencing 28 July 2014 for quarter 1 with NHS England publication commencing September 2014 Local results of response rates to be CQUIN Target for 2014/15 – to conduct survey in Quarter 1 (achieved)	(a) Survey completion criteria variable between NHS organisations per quarter. Survey to include 'NHS Workers' and not restricted to UHL staff therefore creating difficulty in comparisons between organisations as unable to identify % response rates. No guidance available regarding how NHS England will present the data published in September 2014, i.e. same format at FFT for Patients or format for National Staff Opinion and Attitude Survey. Lack of triangulation of Friends and Family Test for Staff results with local Pulse Check Results (Work stream One: Classic LiA / Work stream Five: NiA) and other indicators of staff engagement such as National Staff Survey	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014. (17.6) Please see action 17.1	Dec 2014 DHR Mar 2015 DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 18	Lack of effective leadership capacity and capability	**Overall level of risk to the achievement of the objective**	**Current score 3 x 3 = 9**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Director of Human Resources			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Leadership into Action Strategy (2014:16) including six work streams: 'Providing Coaching and Mentoring' by developing an internal coaching and mentoring network, with associated framework and guidance which will be piloted in agreed areas (targeting clinicians at phase 1).	Quarterly Reports to Executive Workforce Board (EWB) as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	UHL Coaching and Mentoring Framework requires development	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians (18.2)	Dec 2014 DHR
'Shadowing and Buddying' by creating shadowing opportunities and devising a buddy system for new clinicians or those appointed into new roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Buddying / Shadowing System Requires Development	System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	Apr 2015 DHR
'Improving local communications and 360 degree feedback' by developing and implementing a 360 Degree feedback Tool for all leaders and developing nurse leaders to facilitate Listening Events in all ward and clinical department areas as set out in Risk 17.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	360 Feedback Tool not yet developed		

	Updates provided to LiA Sponsor group every 6 months on success measures Monthly updates to Nursing Executive Team (NET) meetings via Heads of Nursing per CMG			
'Shared Learning Networks' by creating and supporting learning networks across the Trust, developing action learning sets across disciplines and initiating paired learning.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.			
'Talent Management and Succession Planning' by developing a talent management and succession planning framework, reporting on talent profile across the senior leadership community, aligning talent activity to pay progression and ensuring succession plans are in place for business critical roles.	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Talent Management and Succession Planning Framework requires development at regional and national level with alignment to the new NHS Health Care Leadership Model	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers (18.5)	Mar 2015 DHR
'Leadership Management and Team Development' by developing leaders in key areas, team building across CMG leadership teams, tailored Trust Board Development and devising a suite of internal eLearning programmes	Quarterly Reports to Executive Workforce Board as part of Organisational Development Plan and Learning, Education and Development Update as set out in Risk 16.	Improvement required in senior leadership style and approach as identified as part of Board Effectiveness Review (2014)	Board Coach (on appointment) to facilitate Board Development Session (18.6) Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model (18.7)	Feb 2015 Jan 2015 CE / DHR

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 19	Failure to deliver financial strategy (including CIP).	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 5 x 2 = 10**
Executive Risk Lead(s)	Director of Finance			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Delivering recurrent balance via effective management controls including SFIs, SOs and on-going Finance Training Programme Health System External Review has defined the scale of the financial challenge and possible solutions UHL Service & Financial Strategy including Reconfiguration/ SOC	Monthly progress reports to F&P Committee, Executive Board, & Trust Board Development Sessions TDA Monthly Meetings Chief Officers meeting CCGs/Trusts TDA/NHSE meetings Trust Board Monthly Reporting UHL Programme Board, F&P Committee, Executive Board & Trust Board	(C) Lack of supporting service strategies to deliver recurrent balance	Production of a FRP to deliver recurrent balance within six years (19.2)	Dec 2014 DF
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(C) CIP Quality Impact Assessments not yet agreed internally or with CCGs (c) PMO structure not yet in place to ensure continuity of function following departure of Ernst & Young	Expedite agreement (19.5) PMO Arrangements need to be finalised (19.6)	Oct 2014 DF Oct 2014 DF
Managing financial performance to deliver recurrent balance via SFI and SOs and utilising overarching financial governance processes	Monthly progress reports to Finance and Performance (F&P) Committee, Executive Board and Trust board.	(c) Finance department having difficulties in recruiting to finance posts leading to temporary staff being employed.	Restructuring of financial management via MoC (19.8)	Oct 2014 DF

Financially and operationally deliverable by contract signed off by UHL and CCGs and Specialised Commissioning on 30/6/14	Agreed contracts document through the dispute resolution process/arbitration Regular updates to F&P Committee, Executive Board, Escalation meeting between CEOs/CCG Accountable Officers			
Securing capital funding by linking to Strategy, Strategic Outline Case (SOC) and Health Systems Review and Service Strategy	Regular reporting to F&P Committee, Executive Board and Trust Board	(c) Lack of clear strategy for reconfiguration of services.	Production of Business Cases to support Reconfiguration and Service Strategy (19.10)	Review monthly DF
Obtaining sufficient cash resources by agreeing short term borrowing requirements with TDA	Monthly reporting of cash flow to F&P Committee and Trust Board	(c) Lack of service strategy to deliver recurrent balance	Agreement of long-term loans as part of June Service and Financial plan (19.11)	Oct 2014 DF

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 20	Failure to deliver internal efficiency and productivity improvements.	**Overall level of risk to the achievement of the objective**	**Current score 4 x 4 = 16**	**Target score 3 x 2 = 6**
Executive Risk Lead(s)	Chief Operating Officer			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
CIP performance management including CIP s as part of integrated performance management	Monthly reports to F&P committee and Trust Board. Formal sign-off documents with CMGs as part of agreement of IBPs	(c) PMO structure not yet in place to ensure continuity of function	Recruit substantive staff to vacant posts (20.2)	Feb 2015 COO
Cross cutting themes are established.	Executive Lead identified. Monthly reports to F&P committee and Trust Board	(A) Not all cross cutting themes have agreed plans and targets for delivery	Simplify cross cutting themes to workforce, beds, outpatients and theatres (20.1)	Feb 2015 COO

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 21	Failure to maintain effective relationships with key stakeholders	**Overall level of risk to the achievement of the objective**	**Current score 5x3=15**	**Target score 5x2=10**
Executive Risk Lead(s)	Director of Marketing and Communications			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Stakeholder Engagement Strategy (including a clinical task forceto drive the improvements that come out of learning lessons to improve care)	Annual Stakeholder surveys presented to the Board Feedback from stakeholders in Board 360 as part of Foresight review. BCT strategy and planning Regular meeting with: CCGs and GPs and Health watch(s) Mercury Panel MPs and local politicians TDA / NHSE On-going review of effectiveness of clinical task force via EQB and QAC	(c) No structured key account management approach to commercial relationships (c) Commissioner (clinical) relationships can be too transactional i.e. not creative / transformational.	Appoint to new Head of Partnerships role (21.2)	Dec 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 22	Failure to deliver service and site reconfiguration programme and maintain the estate effectively.	**Overall level of risk to the achievement of the objective**	**Current score 5 x 2 = 10**	**Target score 5 x 1 = 5**
Executive Risk Lead(s)	Director of Strategy			
Link to strategic objectives	A clinically and financially sustainable NHS Foundation Trust			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Capital Monitoring Investment Committee Chaired by the Director of Finance & Procurement – meets monthly. All capital projects are subject to robust monitoring and control within a structured delivery platform to provide certainty of delivery against time, cost and scope. Project scope is monitored and controlled through an iterative process in the development of the project from briefing, through feasibility and into design, construction, commissioning and Post Project Evaluation. Project budget is developed at feasibility stage to enable informed decisions for investment and monitored and controlled throughout design, procurement and construction delivery. Project timescale is established from the outset with project milestone aspirations developed at feasibility stage. Process to follow: • Business case development • Full business case approvals • TDA approvals • Availability of capital • Planning permission • Public Consultation • Commissioner support	Minutes of the Capital Monitoring Investment Committee meetings. Capital Planning & Delivery Status Reports. Minutes of the March 2014 public Trust Board meeting - Trust Board approved the 2014/15 Capital Programme. Project Initiation Document (PID) (as part of UHL's Delivering Care at its Best) and minutes of the May 2014 Executive Strategy Board (ESB) meeting. Estates Strategy - submitted to the NTDA on 20th June in conjunction with the Trust's 5 year directional plan.	(C) Lack of integrated governance framework for the delivery of a sustainable clinical services strategy	Action plan an resource plan in response to the Gateway 0 review to be developed (22.4)	Dec 14

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 23	Failure to effectively implement EPR programme	**Overall level of risk to the achievement of the objective**	**Current score 5 x 3 = 15**	**Target score 3 x 3 = 9**
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Governance in place to manage the procurement of the solution	EPR project board with executive and Non-Executive members. Standard boards in place to manage IBM; Commercial board, transformation board and the joint governance board. UHL reports progress to the CCG IM&T Strategy Board	EPR Board now needs to be re-shaped from procurement to delivery	Review governance arrangements and alignment with other major programmes (23.7)	CIO – Jan 2015
Clinical acceptability of the final solution	Clinical sign-off of the specification. Clinical representation on the leadership of the project. The creation of a clinically led (Medical Director) EPR Board which oversees the management of the programme. Highlight reports on objective achievement go through to the Joint Governance Board, chaired by the CEO. The main themes and progress are discussed at the IM&T clinical advisory group.			
Transition from procurement to delivery is a tightly controlled activity	EPR board has a view of the timeline. Trust Board and ESB have had an outline view of the delivery timelines.	EPR Board now needs to be re-shaped from procurement to delivery	See action 23.7	CIO – Jan 2015

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST – BOARD ASSURANCE FRAMEWORK

Principal risk 24	Failure to implement the IM&T strategy and key projects effectively*Note: Projects are defined, in IM&T, as those pieces of work, which require five or more days of IM&T activity.*	**Overall level of risk to the achievement of the objective**	**Current score** 3x3 = 9	**Target score** 3 x 3 = 9
Executive Risk Lead(s)	Chief Information Officer			
Link to strategic objectives	Enabled by excellent IM&T			

Key Controls(What control measures or systems are in place to assist secure delivery of the objective)	**Assurance Source** (Provide examples of recent reports considered by Board or committee where delivery of the objectives is discussed and where the board can gain evidence that controls are effective).	**Gaps in Assurance (a)/ Control (c)** (i.e. What are we not doing - What gaps in systems, controls and assurance have been identified)	**Actions to Address Gaps**	**Timescale/ Action Owner**
Project Management to ensure we are only proceeding with appropriate projects	Project portfolio reviewed by the ESB every two months. Agreements in place with finance and procurement to catch projects not formally raised to IM&T.			
Ensure appropriate governance arrangements around the deliverability of IM&T projects	Projects managed through formal methodologies and have the appropriate structures, to the size of project, in place. KPIs are in place for the managed business partner and are reported to the IM&T service delivery board			
Signed off capital plan for 2014/15 and 2015/16	2 year plan in place and a 5 year technical in place highlighting future requirements - signed off by the capital governance routes			
Formalised process for assessing a project and its objectives	All projects go through a rigorous process of assessment before being accepted as a proposal			

Appendix two

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
ACTION TRACKER FOR THE 2014/15 BOARD ASSURANCE FRAMEWORK (BAF)

Monitoring body (Internal and/or External):	UHL Executive Team
Reason for action plan:	Board Assurance Framework
Date of this review	**November 2014**
Frequency of review:	Monthly
Date of last review:	October 2014

REF	ACTION	SENIOR LEAD	OPS LEAD	COMPLETION DATE	PROGRESS UPDATE	STATUS
1	**Lack of progress in implementing UHL Quality Commitment.**					
1.4	Include 'discharge letters' and 'clerking documentation' into QC	CN		November 2014	**Complete.** Quality Commitment updated in December to include discharge letter contents and clerking documentation	5
2	**Failure to implement LLR emergency care improvement plan.**					
2.4	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges	COO / LLR MD		Review December 2014	On track	4
2.5	Arrangements for IS to return for a two week in January 2015 (2.5)	COO		January 2015	On track	4
3	**Failure to effectively implement UHL Emergency Care quality programme.**					
3.1	Review effectiveness of specific LLR improvement actions to deliver a reduction in admissions and increase in discharges. **NB:** *Original action reworded by COO – Dec 2014*	COO		February 2015	On track	4
4	**Delay in the approval of the Emergency Floor Business Case.**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

4.1	Regular communication with NTDA	MD		March 2015	Regular communication with the NTDA about the required timeline for approval of the ED business case has continued to ensure all parties understand the critical time dependencies within the scheme. Communication will continue until the submission dates and beyond to keep the NTDA on track therefore this action will be on-going until March 2015. Deadline extended to reflect this.	4
5	**Failure to deliver RTT improvement plan.**					
5.1	Action plans to be developed in key specialities to regain trajectory	COO		~~September~~ ~~October~~ December 2014	Currently behind planned backlog reduction. Additional activity (including super weekends to continue into November) Plans to achieve Trust admitted performance in November will not be realised, backlogs over 18 weeks have reduced but not significantly enough. Weekend working set to continue past November for General surgery.	2
5.2	Act on findings from recently published IST report	COO		~~August~~ ~~October 2014~~ March 2015	UHL plan to implement findings and recommendations to be developed. IST commissioned to be working with the Trust until end March 2015, Project plan developed and action deadline extended to reflect this.	4
6	**Failure to achieve effective patient and public involvement**					
6.1	Update the PPI/stakeholder engagement strategy	DMC		December 2014/ January 2015	In progress board development session held in Sept 14. Final to the Board Dec/ Jan. Deadline extended to reflect this	3
6.2	Revised PPI plan			N/A	This action replicates 6.1 above and will therefore be deleted from future versions of the action tracker	N/A

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

6.3	OD team involvement to reenergise the vision and purpose of Patient Advisors	DMC	PPIMM	~~October~~ November 2014	Date agreed for this session November. Deadline extended to reflect this	3
7	**Failure to effectively implement Better Care together (BCT) strategy.**					
7.4	BCT SOC to be presented at the December 2014 Trust Board meeting for approval. Action reworded by DS – Dec 2014	DS		December 2014	On track	4
8	**Failure to respond appropriately to specialised service specification.**					
8.3	Programme Plan to be developed	DS		April 2015		4
8.7	PID for Local Partnerships to be developed by the Head of Local Partnerships	DS		December 2014	On track	4
9	**Failure to implement network arrangements with partners.**					
	Actions, 8.1, 8.2, 8.3 and 8.5 refer to risk 9. Action 7.3 refer to risk 7, therefore refer above for progress				See risks 7 & 8	
9.2	*Action removed from BAF / action tracker by DS following further review of content of risk number 9.*	N/A		N/A	See risks 7 & 8	N/A
10	**Failure to develop effective partnership with primary care and LPT.**					
10.1	**Action removed from upon request of DS as action encompassed in risk 7.**	N/A		N/A	See risk 7	N/A
11	**Failure to meet NIHR performance targets.**					
12	**Failure to retain BRU status.**					
12.1	BRUs to re-consider theme structures for renewal, identifying potential new theme leads. (12.1)	MD	DR&D	June 2015		4
12.2	BRUs to identify potential recruits and work with UoL/LU to structure recruitment packages.	MD	DR&D	June 2015		4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

12.3	UHL to use RCF to pump prime appointments if possible and LU planning new academic appointments to support lifestyle BRU.	MD	DR&D	June 2015		4
12.4	UoL and LU to ensure successful applications for Silver swan status and. Individual medical school depts will need to separately apply for Athena Swan Silver status.	MD	DR&D	March 2016	VC and President has re-constituted group leading Medical School Bid with appointment of new project manager.	4
12.5	Special meeting of Joint BRU Board: planning to secure BRU funding at the next NIHR competition. Further meetings planned.	MD	DR&D	March 2015		4
13	**Failure to provide consistently high standards of medical education.**					
13.1	To work with Finance to ensure transparency and accountability of undergraduate and postgraduate medical training tariffs *(reworded October 2014)*	MD	AMD (CE)	~~October 2014~~ January 2015	Work on investigating this is taking longer than anticipated and requires coordination with the new Director of Finance.	3
13.2	Ensure appropriate Consultant Job descriptions include job planning	MD	AMD (CE)	January 2015		4
13.3	Develop appraisal methodology for educational roles	MD	AMD (CE)	January 2015	Information to support appraisers developed and include in appraiser development sessions. A new module in Prep is being explored to support appraisal of education roles	4
13.4	Disseminate approved appraisal methodology to CMGs.	MD	AMD (CE)	~~December~~ February 2015	Date changed as appraisal methodology will not be developed until January 2015 (see action 13.3)	3
13.5	Work to relocate anomalous budgets to HR as other Foundation doctor contracts	MD	AMD (CE)	~~January~~ April 2015	Budgets will be relocated at the beginning of 2015/16 financial year to avoid potential confusion of transferring part year budgets. Deadline changed to reflect this.	3
14	**Lack of effective partnerships with universities.**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

14.1	UHL CE to meet with VC in near future.	CEO		March 2015	UHL Chairman has already met with VC	4
14.2	LU strategy to be discussed at joint BRU board.	MD	DR&D	March 2015		4
14.3	UHL membership of NCSEM management board	MD	DR&D	March 2015		4
14.4	Meeting with LU VC, UHL MD, UHL DRD and BRU Director to discuss strategy	MD	DR&D	June 2015		4
14.5	Develop regular meeting with DMU	MD	DR&D	June 2015		4
15	**Failure to adequately plan the workforce needs of the Trust.**					
15.4	Develop Innovative approaches to recruitment and retention to address shortages.	DHR		March 2015	Medical Workforce Strategy in place and to be updated following feedback from HEEM quality visit and the Clinical Senate. Aim to present to January 2015 Board	4
15.6	Delivering our Employer Brand group to share best practice and development social media techniques to promote opportunities at UHL	DHR		March 2015	Webpage review originally planned for end of August now changed to end of January 2015. Resource identified to develop website. Hotspots areas now producing career profiles which are successfully attracting into difficult to recruit areas.	4
15.7	Development of internship model and potential management trainee model supported by robust education programme and education scheme	DHR		November 2014	**Complete.**	5
15.8	Consultant recruitment review team to develop professional assessment centre approach to recruitment utilising outputs to produce a development programme	DHR		April 2015	Proposal prepared for review by DHR and MD. Agreed to make small adjustments to selection process in first instance and evaluate impact.	4
16	**Inability to recruit and retain staff with appropriate skills.**					
16.1	Team Health Dashboard to be developed and implemented	DHR		~~September 2014~~ December 2014	Full dashboard functionality will be live from the end of December 2014. Deadline extended to reflect this.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

16.2	eUHL system updates required to meet Trust needs	DHR		March 2015	Working through single supplier specification with Head of Procurement and IBM colleagues. Draft documents will be consulted on during November 14	4
16.3	Robust ELearning policy and procedures to be developed to reflect P&GC approach	DHR		January 2015	The E-learning policy and procedures will form part of the Core Training Policy currently under development and due for final approval by end of January 2015. Deadline extended to reflect this	4
17	**Failure to improve levels of staff engagement**					
17.1	Team Health Dashboard to be developed – mock up to be presented to EWB at September 2014	DHR		March 2015	Please refer to Item 16.1	4
17.2	Ensure IBM aware of requirements.	DHR		March 2015	CIO aware of LiA MoC associated with IBM related projects. Meetings held with IBM representatives to coach and guide on LiA principles and approach. Further plans to include LiA in pilot of Paediatric Areas for Electronic Document Record Management. MoC information included on Organisational Health Dashboard	4
17.3	HR Senior Team aware of need to include Engagement event prior to formal consultation (with MoC impacting on staff – more than 25 people)	DHR		March 2015	MoC (HR) including LiA as a precursor to formal consultation. A number of events have been concluded using LiA. A specific resource for LiA MoC has been developed	4
17.4	Include as regular agenda item on LiA sponsor group identifying activity and anticipated resources required	DHR		March 2015	Each of the LiA Work streams is included as standing items on LiA Sponsor Group meetings.	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

17.6	Develop draft internal reports in development in readiness for possible analysis methodology used by NHS England in September 2014.	DHR		~~September~~ ~~October~~ December 2014	**Friends and Family Test for Staff:** Submission of first UNIFY report submitted to NHS England in compliance with deadline and CQUIN target. Internal analysis of free text themes being undertaken. UHL data to be included in CE Briefing. Cannot be benchmarked against other organisations as NHS England has still not published results. Awaiting information from NHS England on analysis methodology. Deadline extended to reflect this	4
18	**Lack of effective leadership capacity and capability**					
18.2	Improve internal coaching and mentoring training provision in collaboration with HEEM and at phase 1 establish process for assigning coaches and mentors to newly appointed clinicians	DHR		December 2014	Mentoring / Coaching development programme in place. Bespoke Consultant Programme completed 10/14 in partnership with HEEM	4
18.3	'Shadowing and Buddying' System being developed in partnership with HEEM and Assistant Medical Director to ensure support provided to newly appointed Consultants at initial phase (18.3)	DHR		April 2015	Consultant Forum in place	4
18.5	Support national and regional Talent Management and Succession Planning Projects by National NHS Leadership Academy , EMLA and NHS Employers	DHR		March 2015	UHL staff nominated to access National Leadership Academy Programme based on talent conversations.	4
18.6	Board Coach (on appointment) to facilitate Board Development Session	DHR		~~October 2014~~ February 2015	Board development session completed on 16/10/14. Board Coach identified subject to agreement with the Trust Chairman. Awaiting decision and deadline extended to reflect this	4

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

18.7	Update of UHL Leadership Qualities and Behaviours to reflect Board Development, UHL 5 Year Plan and new NHS Healthcare Leadership Model	DHR/ CE		January 2015	As above, at the initial phase the Trust Board will discuss and agree : (a) the overall leadership model the Board and Executive Team are seeking to build; and (b) the Board culture that it is seeking to shape and exemplify.	4
19	**Failure to deliver financial strategy (including CIP).**					
19.2	Production of a FRP to deliver recurrent balance within three years	DF		~~August Review September 2014~~ December 2014	On track, though the timescale is 6 years subject to TDA approval of the LTFM. Awaiting formal feedback from the TDA on the LTFM submitted on 20/6/14. Following the Board to Board with the TDA further work will be required on the financial strategy before December 2014	3
19.5	Expedite agreement of CIP quality impact assessments with UHL and CCGs	DF		~~August Review September~~ October 2014	UHL continues to submit CIP quality impact statements to the CCGs where appropriate, following sign off by the Chief Nurse and Medical Director. Quality impact statements requested from the CCGs for their QIPP plans	3
19.6	PMO Arrangements need to be finalised	DF		~~August~~ October 2014	Whilst the structure is agreed we have extended the EY contract until the end of 10/14. Deadline extended to reflect this	3
19.8	Restructuring of financial management via MoC	DF		~~July Review August~~ October 2014	MoC consultation ended 6/6/14; recruitment to vacant posts on-going. All senior posts have now been successfully recruited to – all will be in post by the end of 10/14. Deadline extended to reflect this	3

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

19.10	Business Cases to support Reconfiguration and Service Strategy	DF		~~July Review September 2014~~ On-going as per individual business case timeline	The TDA have now confirmed that the previously submitted IBP/LTFM will act as the overall SOC. Individual business cases will be submitted to the Trust Board and TDA as per the overall reconfiguration strategy	4
19.11	Agreement of long-term loans as part of June Service and Financial plan	DF		~~June August~~ October 2014	Trust received a £29m cash loan in line with the Plan and trajectory submitted to the TDA. Application for further loans submitted and on-going work with the TDA between now and 17/10/14 when the application will be formally reviewed by ITFF panel. Application submitted to the ITFF panel for review at the meeting on 17 October 2014.	3
20	**Failure to deliver internal efficiency and productivity improvements.**					
20.1	Simplify cross cutting themes to workforce, beds, outpatients and theatres. Action reworded by COO- Dec 2014	COO		~~August 2014~~ February 2015	On track	4
20.2	Recruit substantive staff to vacant posts to ensure continuity of function of PMO	COO		February 2015	On track	4
21	**Failure to maintain effective relationships with key stakeholders**					
21.2	Appoint to new Head of Partnerships role	DS		December 2014	On track	4
22	**Failure to deliver service and site reconfiguration programme and maintain the estate effectively**.					
22.4	Action plan an resource plan in response to the Gateway 0 review to be developed	DS		December 2014	On track.	4
23	**Failure to effectively implement EPR programme**					
23.7	Review governance arrangements and alignment with other major programmes	CIO		Jan 2015	On track	4
24	**Failure to implement the IM&T strategy and key projects**					

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Key

CEO	Chief Executive
DF	Director of Finance
MD	Medical Director
AMD	Assistant Medical Director
COO	Chief Operating Officer
DHR	Director of Human Resources
DDHR	Deputy Director of Human Resources
DS	Director of Strategy
DR&D	Director of R&D
DMC	Director of Marketing and Communications
DCQ	Director of Clinical Quality
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CD	Clinical Director
CMGM	Clinical Management Group Manager
DDF	Deputy Director Finance
CN	Chief Nurse
AMD (CE)	Associate Medical Director (Clinical Education)
PPIMM	PPI and Membership Manager

Status key:	5	Complete	4	On track	3	Some delay – expect to completed as planned	2	Significant delay – unlikely to be completed as planned	1	Not yet commenced	0	Objective Revised

Risk ID	CMG	Specialty	Risk Title	Review Date Opened	Description of Risk	Risk subtype	Controls in place	Impact	Likelihood	Current Risk Score	Action summary	Target Risk Score	Risk Owner
2445	Emergency and Specialist Medicine		SpR gaps on the ESM CMG Medical Rota	31/12/2014 04/11/2014	Causes: These vacancies are caused by a national shortage of trainees applying for specialties which have a general medicine component. This is further compounded by sickness and unexpected absence which makes the rotas very vulnerable to short notice absences. Given the high number of vacancies the CMG is unable to fill these all with locum and agency staff. Consequences: There is a delay in assessing patients admitted to the assessment units out of hours or overnight. This may result in delays in recognising severity of illness or initiation of treatment which in may cause harm (death, longer LoS). Delays in decision making which means patients cannot be moved from the assessment unit to base ward beds. This may have the knock on effect of causing crowding in the ED which endangers patients there (see overcrowding in ED risk - number 2236). There is a risk to patients coming to harm on the base wards if there are insufficient senior medical staff to assess unwell patients both in assessment units and on the wards. Staff are unable to take rest breaks which may impact on the There is a risk that trainees will be removed from UHL by HE	Patients	All known vacancies are out to locum bookers - the CMG actively recruits locum and agency staff and works closely with locum bookers and Maria McAuley in order to maximise fill rates. Fortnightly recruitment meetings for medical vacancies (all grades) with HR and service managers to proactively manage vacancies. Recruitment into non training grade positions from international graduates in order to fill gaps in the SpR rota. 8 day in advance schedule for on call rota produced daily and reviewed by senior manager to ensure gaps are cited and acted upon issued daily. 2 weekly advance scheduling shared with base wards to identify short falls and promote action. Monitoring in line with Trust requirements undertaken across key periods during the working year. Maintain advanced look forward for requests to maximise fill of gaps and ensure that all request are a minimum 6 weeks in advance for known vacancies. Daily review of skill mix and reallocation of SpRs following risk and dependency assessments across the CMG.	Major	Almost certain	20	Continue to progress recruitment actively and monitor deanery allocations - 31/12/14. Actively engage medical director for education (Sue Carr) and HEEM to ensure all mid and long term solutions to attracting and retaining SpRs are pursued - 31/12/14. Creative short term appointments offering fixed term opportunities within specialities to maximise interest within the local market - 31/12/14. Continue and progress the allocation of LAS doctors into the Acute rota - replacing the intended LGH team of Trust registrars (all to be in post by mid December) - 31/12/14. Trust to explore other ways of staffing medical rotas (ANPs etc) - 31/03/15.	9	CFRE

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 8 January 2015

COMMITTEE: Quality Assurance Committee

CHAIRMAN: Dr S Dauncey, QAC Chair

DATE OF COMMITTEE MEETING: 15 December 2014

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- **None.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR THE INFORMATION OF THE TRUST BOARD:

- **Minute 109/14/1 (Provision of Home Care Schemes – although a long term solution was in place, there was a need for focus on the short term solution), and**
- **Minute 111/14/1 (Triangulation of Patient Feedback).**

DATE OF NEXT COMMITTEE MEETING: 29 January 2015

Dr S Dauncey
QAC Chairman
2 January 2015

Trust Board Paper J
DRAFT **UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST**

MINUTES OF A MEETING OF THE QUALITY ASSURANCE COMMITTEE HELD ON MONDAY 15 DECEMBER 2014 AT 12:30PM IN THE LARGE COMMITTEE ROOM, LEICESTER GENERAL HOSPITAL

Voting Members Present:
Dr S Dauncey – Non-Executive Director (Acting Chair)
Mr J Adler – Chief Executive
Dr K Harris – Medical Director
Ms J Wilson – Non-Executive Director

In Attendance:
Mr M Caple – Patient Adviser (non-voting member)
Mr I Crowe – Non-Executive Director
Miss M Durbridge – Director of Safety and Risk
Mrs S Hotson – Director of Clinical Quality
Mrs H Majeed – Trust Administrator
Ms C O'Brien – Chief Nurse and Quality Officer, East Leicestershire CCG (non-voting member)
Ms C Ribbins – Deputy Chief Nurse
Mr K Singh – Trust Chairman

RESOLVED ITEMS **ACTION**

106/14 APOLOGIES

Apologies for absence were received from Ms R Overfield, Chief Nurse; Mr P Panchal, Non-Executive Director and Professor D Wynford-Thomas, Non-Executive Director and Dean of the University of Leicester Medical School.

107/14 MINUTES

Resolved – that the Minutes of the Quality Assurance Committee meeting held on 26 November 2014 (papers A and A1 refer) be confirmed as a correct record.

108/14 MATTERS ARISING REPORT

108/14/1 Matters Arising Report

Members received and noted the contents of paper 'B', noting that those actions now reported as complete (level 5) would be removed from future iterations of this report. Members specifically reported on progress in respect of the following actions:-

(i) Minute 98/14/1 c (regarding whether it would be appropriate for a Non-Executive Director to sit on the External Complaints Panel as a observer) – further to a discussion on this matter, the general consensus of the Committee was that it would not be appropriate for a Non-Executive Director to sit on the External Complaints Panel. This Panel needed to be independent, however assurance from this Panel would be provided on a quarterly basis to the EQB and to the QAC by exception; **DSR**

(ii) Minute 78/14/5 (regarding appropriate messaging of the nursing workforce indicators, once national benchmarking/RAG ratings were available) – the Deputy Chief Nurse advised that the tool required to undertake this work required review. Further to this, the date of completion of this action would be confirmed as noted on the matters arising report;

(iii) Minute 77/14/2 (Renal Transplant Plan Update) – the Chief Executive provided a brief update on the possibility of appointing two Transplant Consultants, and

(iv) Minute 66/14/1 (EPMA Update) – the Chief Executive advised that an update on EPMA had been provided at the EQB meeting on 2 December 2014.

Therefore, a further update would now be provided to QAC on 29 January 2015 as noted on the matters arising report.

Resolved – that the matters arising report (paper B refers) and the actions outlined above be noted and undertaken by those staff members identified. **DSR**

109/14 SAFETY

109/14/1 Provision of Homecare Schemes at UHL

Further to Minute 65/14/1 of 27 August 2014, the Medical Director presented paper C, an update on current issues with the supply of medicines via Homecare schemes and actions taken to improve quality and patient experience. He advised that the issue with homecare suppliers was a national one and the Clinical Services and Imaging CMG continued to progress on the proposal to develop an insourced subsidiary company to provide homecare services. Work was also underway on other long term actions which had been identified through the review of individual schemes, however the current focus remained on the short term stability. In the interim, supply would be transferred to Lloyds Pharmacy or UHL where there was capacity to do so safely.

In discussion on this item, members queried whether a team of staff was proactively managing this issue and whether appropriate focus was being given to this matter. It was noted that the Pharmacy team was currently focussing on the short term stability and the right steps were being taken. In further discussion on the reason for the delay in developing the full business case for an in-house insourced company, the Medical Director undertook to ensure that an update on the business case would be provided to the QAC in April 2015 and an update on any risks would be provided by exception. **MD**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Medical Director be requested to ensure that an update on the business case to develop an insourced subsidiary company to provide homecare services be provided to the QAC in April 2015 and an update on any risks be provided by exception. **MD**

109/14/2 TTO Error Rate

Further to Minute 67/14/5 of the Finance and Performance Committee on 25 June 2014 and also further to discussion of this item at EQB on 2 December 2014 (action note 4.2.2 refers), the Medical Director presented paper D, which reported on the TTO prescribing error rates and actions in place to reduce these errors. He highlighted that it was not possible to benchmark this information as it was not reported nationally. An audit in October 2014 showed an overall error rate of 59% and TTOs without errors took an average of 7 minutes to be professionally checked by a Pharmacist in comparison to 25 minutes for those with errors.

Error rates for areas using the ICE/EPMA interface were higher than for non-interface TTOs. However, it was not believed that the interface had introduced any additional risk to patients and there might be a decreased risk due to reduction in serious errors. One of the other reasons for the errors that had been identified through the audit was that the impatient prescription was not subsequently amended to correct any discrepancies further to a drug history being taken by the Pharmacist on admission of the patient.

In response to a query from Ms J Wilson, Non-Executive Director regarding the incentive for CMG staff to resolve this issue - noting that this might be considered a pharmacy issue by CMG staff - the Medical Director advised that trajectories for improvement at CMG level were being considered.

Responding to a query from the Chief Executive in respect of the “harm” caused due to

these errors, the Director of Safety and Risk advised that although the number of reported errors was high, the harm was very low. In further discussion on the harm caused, the Chief Executive suggested that a step back needed to be taken to review the whole process to ascertain whether any further actions apart from those already on the action plan could be taken to reduce TTO error rates. It was requested that an update be provided to QAC in April 2015. **MD/CP**

<u>Resolved</u> – that (A) the contents of this report be received and noted, and

(B) the Medical Director with support from the Chief Pharmacist be requested to take a step back to ascertain the reasons for TTO errors and any further actions that could be taken to reduce the error rate and an update be provided to QAC in April 2015. **MD/CP**

109/14/3 <u>Patient Safety Report</u>

The Director of Safety and Risk presented paper E, which provided a monthly update on internal safety issues and serious incidents and external safety news and developments. In her presentation of the report, the Director of Safety and Risk particularly highlighted those points outlined on the first covering page, in particular the key safety issue this month, duty of candour legislation and improvements from the safety walkabout programme.

The Committee was particularly invited to note that:-

(a) 7 SUIs had been escalated in November 2014, and
(b) 2 RCA investigations and actions plans had been completed in November 2014, the learning of which had been shared through EQB, CMG Quality and Safety meetings and the Adverse Events Committee.

In discussion on this item, members:

(i) requested that assurance be provided outside the meeting in respect of staffing cover in the Emergency Department over the Christmas period; **DCN**
(ii) requested assurance on the SUI relating to failure to act on results – in response, the Medical Director advised that this SUI was particularly in relation to failure to act on an Early Warning Score. In respect of acting upon results, a group had now been established to take forward this workstream and focus on this matter was also being given at EQB;
(iii) queried the reason for the constant use of bank staff – in response, the Deputy Chief Nurse advised that the fill rates of bank staff now exceeded the agency staff and therefore the perception was that there had been constant use of bank staff. However, the reason for this was that the number of agency staff had now reduced;
(iv) queried regarding the absence of thematic review of SUIs – it was noted that this was usually included in the quarterly patient safety reports which were submitted to QAC, and
(v) requested that a review of the safety walkabout programme be undertaken – the Director of Safety and Risk undertook to provide an update to EQB in February 2015. **DSR**

<u>Resolved</u> - that (A) the contents of this report, and the additional verbal information provided, be received and noted;

(B) assurance be provided outwith the meeting to members of QAC regarding the staffing cover in the Emergency Department over the Christmas period, and **DCN**

(C) the Director of Safety and Risk be requested to present a report on the review of the safety walkabout programme to the EQB in February 2015. **DSR**

109/14/4 Report from the Deputy Chief Nurse

Resolved – that this Minute be classed as confidential and taken in private accordingly.

110/14 QUALITY

110/14/1 Nursing Workforce Report

The Deputy Chief Nurse presented paper G, which detailed information in respect of the latest nursing staffing in post figures, the current recruitment position and the mitigation of workforce gaps.

UHL's real time staffing summary would support UHL's reporting in relation to NHS England's, 'Hard Truths Commitments Regarding the Publishing of Staffing Data'. Appendix 1 detailed UHL's monthly return for October 2014. Six wards were under the 80% threshold in relation to actual versus planned staffing, this was all in the Health Care Assistant line, for day shifts. There were sufficient Registered Nurses on shift throughout the month to counter-balance this, four of the areas having had over 100% planned Registered Nurse staffing throughout the month.

In respect of international recruitment, it was noted that 206 international nurses had joined the Trust to date. Further recruitment was planned with a further 32 international recruits joining the Trust in November 2014. The plan was for 5 cohorts of up to 30 nurses to be recruited throughout 2015. The Deputy Chief Nurse highlighted that this number could be increased in line with availability of training facilities. The Chief Executive noted that provision of an additional/external training facility should not be an issue to limit recruitment and requested the Deputy Chief Nurse to provide data outside the meeting on the maximum number of international recruits that it would be possible to recruit in 2015. **DCN**

In response to a query from the Patient Adviser, the Deputy Chief Nurse advised that when CMGs were unable to manage their staffing issues, Corporate Nursing became involved and actions were put in place to minimise the risk and ensure safe staffing levels were in place. It was also noted that the retention rate of the international nurses was excellent.

Members noted that the current nursing vacancy rate was 10% and the Chief Executive queried what a "reasonable" vacancy rate would be – in response, the Deputy Chief Nurse advised that a 5.5%-6% vacancy rate would be considered ideal as there would be a level of flexibility to move staff. The Chief Executive requested that a strategy be developed to drive down to that level of vacancy and suggested that the number and size of cohorts of international nursing staff required to fill the gap be pursued. **DCN**

The Trust Chair suggested that consideration be given to recruiting nurses from outside the EU noting that the pool from which such staff could be recruited was diminishing given that nurse recruitment was a national issue. However it was noted that there were a number of constraints if recruitment was to go ahead outside the EU. The Committee Chair requested that the constraints be explored. **DCN**

Resolved – that (A) the contents of this report and the additional verbal information provided, be received and noted, and

(B) the Deputy Chief Nurse be requested to:- **DCN**
(i) provide data on the maximum number of international nurses that it would be possible for the Trust to seek to recruit in 2015;
(ii) develop a strategy to drive down the level of vacancy (from 10% to 5.5%) and confirm the number and size of international nurse cohorts that would be required to fill this gap;

(iii) explore the constraints for recruiting outside the EU and report back to the Quality Assurance Committee, and
(iv) report back to the Quality Assurance Committee on the actions identified in points (i), (ii) and (iii) above.

111/14 PATIENT EXPERIENCE

111/14/1 Triangulation of Patient Experience – Quarter 2

The Deputy Chief Nurse presented paper H, an update on the triangulation of patient feedback for quarter 2 (July-September 2014) of 2014-15. The top two subject themes were waiting times and medical care. Comparing quarters one and two showed an increase in feedback from patients relating to nursing care (perceived staffing levels), hotel services (availability of refreshments and catering standards) and lastly administration (appointment systems).

Members were pleased that table 5 of the report included a list of all feedback that could be attributed to a specific area or Clinical Management Group such as Friends and Family Test free text comments, Message to Matron and all types of complaints. The Deputy Chief Nurse thanked Ms H Leatham, Head of Nursing and Mr C Walker, Clinical Audit Manager for their efforts to prepare this report.

The Patient Adviser commended the level of detail in the report, however, expressed concern that the CMGs did not consistently discuss the issues highlighted in this report at their CMG Board meetings. It was noted that the patient experience team would be meeting the Clinical Directors and General Managers to highlight the issues.

In further discussion on the theme relating to "waiting times", it was noted that there needed to be focus beyond CMGs and there was need for ownership at a Corporate level. It was noted that the Chief Operating Officer had been leading a project on outpatients and taking forward any issues relating to waiting times. However, members noted the need for triangulation of the cross-cutting projects. The Deputy Chief Nurse undertook to provide quarterly updates on this matter to the QAC. **DCN**

Resolved – that (A) the contents of this report be received and noted, and

(B) the Deputy Chief Nurse be requested to provide an update on the triangulation of the cross-cutting projects following patient feedback to the QAC via the quarterly reports on patient experience. **DCN**

112/14 ITEMS FOR THE ATTENTION OF QAC FROM EQB

112/14/1 EQB Meeting of 4 November 2014 – Items for the attention of QAC

Resolved – that the minutes of the EQB meeting held on 4 November 2014 (paper I refers) be received and noted.

112/14/2 EQB Meeting of 2 December 2014 – Items for the attention of QAC

The Chief Executive reported orally and highlighted that the endoscopy services at the Leicester General Hospital had failed the recent JAG accreditation visit due to issues with the physical environment. The CHUGGS CMG had a plan in place to transfer Endoscopy services to another site and a report would be presented to a future meeting of the EQB.

Resolved – that the position be noted.

113/14 ITEMS FOR INFORMATION

113/14/1 Outcome of the Cytology Screening Programme

The Director of Clinical Quality reported orally and advised that a recent inspection visit by the Cervical Screening Quality Assurance Team had been undertaken in September 2014 to assess the performance and organisation of the cervical screening programme operated in the Trust against the NHS Cancer Screening Programmes national standards. A number of recommendations had followed from this visit and one of the key findings was that the contractual and governance arrangements for the cervical screening programme activities were not clear. It was noted that progress in addressing the recommendations would be reviewed at EQB in January 2015.

Resolved – that the contents of paper J be received and noted.

113/14/2 Ward Performance Review Tool – Quarter 2 (2014-15)

The Committee Chair noted the improvement in results across all domains in respect of the ward performance review tool.

Resolved – that the contents of paper K be received and noted.

113/14/3 Quarterly PLACE Audit Results

Resolved – that the contents of paper L be received and noted.

114/14 MINUTES FOR INFORMATION

114/14/1 Finance and Performance Committee

Resolved – that the public Minutes of the 26 November 2014 Finance and Performance Committee meeting (paper M refers) be received and noted.

114/14/2 Executive Performance Board

Resolved – that the action notes of the 25 November 2014 Executive Performance Board meeting (paper M refers) be received and noted.

115/14 ANY OTHER BUSINESS

115/14/1 There were no items of any other business.

116/14 IDENTIFICATION OF ANY KEY ISSUES FOR THE ATTENTION OF THE TRUST BOARD

Resolved – that the QAC Chair be requested to bring the following issues to the attention of the Trust Board at its meeting on 22 December 2014: **Acting Chair**

- **Minute 109/14/1 (Provision of Home Care Schemes – although a long term solution was in place, there was a need for focus on the short term solution);**
- **Minute 10914/4 (Confidential Report from the Deputy Chief Nurse), and**
- **Minute 111/14/1 (Triangulation of Patient Feedback).**

117/14 DATE OF NEXT MEETING

Resolved – that the next meeting of the Quality Assurance Committee be held on Thursday, 29 January 2015 from 1:00pm until 4:00pm, venue to be confirmed.

The meeting closed at 2.44pm.

Cumulative Record of Attendance (2014-15 to date):

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
J Adler	9	7	77%	*R Overfield*	9	7	77%
S Dauncey (Acting Chair)	9	8	88%	*P Panchal*	9	5	55%
K Harris	9	7	77%	*J Wilson*	9	8	88%
K Jenkins	1	0	0%	*D Wynford-Thomas*	9	3	33%

Non-Voting Members

Name	*Possible*	*Actual*	*% attendance*	*Name*	*Possible*	*Actual*	*% attendance*
*M Caple**	9	7	77%	*K Singh*	3	3	100%
I Crowe	2	3	66%	*M Traynor*	3	0	0%
*C O'Brien – East Leicestershire/Rutland CCG**	9	5	55%	*M Williams*	3	0	0%

Hina Majeed, **Trust Administrator**

University Hospitals of Leicester NHS
NHS Trust

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT BY TRUST BOARD COMMITTEE TO TRUST BOARD

DATE OF TRUST BOARD MEETING: 8 January 2015

COMMITTEE: Finance and Performance Committee

CHAIR: Ms J Wilson, Non-Executive Director

DATE OF COMMITTEE MEETING: 18 December 2014

RECOMMENDATIONS MADE BY THE COMMITTEE FOR CONSIDERATION BY THE TRUST BOARD:

- **Minute 134/14 – Emergency Floor draft Full Business Case;**
- **Confidential Minute 135/14 – report by the Director of Strategy, and**
- **Minute 136/14 – Financial Planning Guidance for 2015-16.**

OTHER KEY ISSUES IDENTIFIED BY THE COMMITTEE FOR CONSIDERATION/ RESOLUTION BY THE TRUST BOARD:

- **Confidential Minute 140/14/4 – report by the Director of Estates and Facilities.**

DATE OF NEXT COMMITTEE MEETING: 29 January 2015

Ms J Wilson
Finance and Performance Committee Chair

5 January 2015

DRAFT

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE, HELD ON THURSDAY 18 DECEMBER 2014 AT 8.30AM IN THE BOARD ROOM, VICTORIA BUILDING, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Ms J Wilson – Non-Executive Director (Committee Chair)
Mr J Adler – Chief Executive
Colonel (Retired) I Crowe – Non-Executive Director
Mr R Mitchell – Chief Operating Officer (for Minutes 140/14/3 to 142/14/2 inclusive)
Mr P Traynor – Director of Finance
Mr M Traynor – Non-Executive Director

In Attendance:
Ms L Bentley – Head of Financial Management and Planning
Mr A Chatten – Director of Estates and Facilities (for Minutes 140/14/2 to 140/14/4)
Mr J Clarke – Chief Information Officer (for Minute 140/14/1)
Mr P Gowdridge – Head of Strategic Finance (for Minute 134/14)
Ms E MacLellan-Smith – Ernst Young (for Minute 142/14/2)
Mrs K Rayns – Trust Administrator
Ms K Shields – Director of Strategy
Mr K Singh – Trust Chairman (up to and including Minute 142/14/2)
Mr G Smith – Patient Adviser

RECOMMENDED ITEMS **ACTION**

134/14 EMERGENCY FLOOR – DRAFT FULL BUSINESS CASE

Further to the Finance and Performance Committee's consideration of the revised emergency activity assumptions on 26 November 2014 (Minute 126/14/3 refers), paper C provided members with a briefing on the critical issues to ensure successful delivery of the new emergency floor development and sought endorsement of the Full Business Case for onward approval by the Trust Board on 8 January 2015.

In presenting the paper, the Chief Executive and the Director of Strategy confirmed that Commissioners would be asked to write a letter of support for the FBC – in the same way that they had already provided a letter of support for the OBC. They summarised the key risks surrounding timescales for NTDA approvals processes, the impact of the forthcoming general election in May 2015 (noting that purdah would commence on 20 March 2015), and any potential future changes in NHS investment strategy following that election.

Colonel (Retired) I Crowe, Non-Executive Director, and member of the Emergency Floor Project Board reported verbally on that Project Board's support of the key changes and the excellent progress being made in alignment of the financial business case with the workforce plan. He noted the inherent risks with the scheme, stressing the importance of adherence to the approvals timetable and the need for UHL to be agile in responding to any TDA queries on the business case. He sought and received assurance that all the recommendations arising from the Gateway 2 review had been addressed and commented on the importance of achieving a green-rating for the Gateway 3 review.

In response to a query, the Chief Executive agreed to clarify the continuity arrangements for Chairmanship of the Emergency Floor Project Board, in light of the Medical Director's impending retirement. The Director of Finance advised that he now attended these Project Board meetings. **CE**

During discussion on the executive summary and the full business case, members of the Finance and Performance Committee:-

(1) noted the ongoing work to finalise the design of assessment areas. Within the physical and financial constraints of the scheme, some room sizes were currently non-compliant with the relevant DoH Health Building Note (HBN). However, an independent review was being carried out to confirm the derogations and alignment with clinical operational policies and there would be no material impact upon the FBC;

(2) commented that the activity and expenditure assumptions were based upon the 2014-15 outturn and that any variations to this baseline would have an associated operational and financial impact. The Emergency Floor Project Board had provided assurance regarding the flexible functionality of the new development which was deemed to be future-proofed for the next 20 years, including the ability to build an additional floor above the new development (if required). In addition, it was noted that the marginal rate emergency tariff (MRET) was likely to increase from 30% to 50% for any activity above the 2014-15 threshold;

(3) queried whether UHL's key stakeholders were aware of the refreshed emergency activity assumptions and whether the Trust should be engaging with and seeking additional support of the FBC from key stakeholders. In response, the Chief Executive confirmed that a unified approach to consultation and engagement would be maintained within the Better Care Together Programme;

(4) requested additional information relating to the capitalisation of expenditure, VAT recovery plans and treatment of inflation within the financial case. The Director of Finance confirmed that the Trust was audited regularly on its use of capital funding and that specialist advisors were engaged in this aspect. In respect of VAT recovery, a Trust-wide review was underway to explore the scope for additional savings. The Director of Finance agreed to brief Mr M Traynor, Non-Executive Director on the more detailed financial elements of the scheme outside the meeting (including the allowance for inflation); **DF**

(5) received additional background information regarding the Procure 21 (P21) procurement framework and the associated treatment of contingency sums and optimism bias in respect of ensuring best value for money within the guaranteed maximum price, and

(6) requested that the full business case be updated prior to submission to the 8 January 2015 Trust Board meeting, to articulate the risks surrounding forecast emergency activity levels and the scope for implementing contingency plans in the event that the planned reductions in activity did not materialise. **DS**

<u>Recommended</u> – that (A) the Chief Executive be requested to clarify the arrangements for Chairmanship of the Emergency Floor Project Board and appropriate continuity; **CE**

(B) the Director of Finance be requested to brief Mr M Traynor, Non-Executive Director on the more detailed financial elements of the scheme (including capitalisation, VAT recovery and inflation); **DF**

(C) the risks surrounding forecast emergency activity levels and associated contingency plans be clearly articulated within the Emergency Floor FBC, and **DS**

(D) subject to the articulation of risks surrounding forecast activity levels (point C above refers), the Emergency Floor FBC be endorsed for Trust Board approval on 8 January 2015. **DS**

135/14 REPORT BY THE DIRECTOR OF STRATEGY

Recommended – that this Minute be classed as confidential and taken in private on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

136/14 FINANCIAL PLANNING 2015-16 (INCLUDING DRAFT TARIFF GUIDANCE)

The Director of Finance introduced paper H, providing the Finance and Performance Committee with a briefing on the key changes contained within the draft 2015-16 tariff guidance (including the risks and opportunities), the financial planning process and timescales and the high level principles for delivering an improved financial position for 2015-16. Discussion took place regarding UHL's participation in the formal collaborative consultation process and the potential impact upon contractual negotiations with CCGs and Specialised Commissioners for 2015-16.

Section 3 of paper H detailed the process for developing the 2015-16 financial plan and set out the key planning assumptions. The planning timetable was provided at appendix 1. Members noted that the initial headline plan data was required to be submitted to the NTDA on 13 January 2015. Subject to clarification of the provisional 2015-16 planning guidance, the Finance and Performance Committee endorsed the submission of a deficit first cut plan of £36.1m.

Recommended – that, subject to clarification of the draft 2015-16 planning guidance, the first cut deficit financial plan for 2015-16 of £36.1m be endorsed, for submission to the NTDA by 13 January 2015.

RESOLVED ITEMS

137/14 APOLOGIES

Apologies for absence were received from Dr S Dauncey, Non-Executive Director and Mr M Williams, Non-Executive Director.

138/14 MINUTES

The Committee Chair commented upon the continued non-availability of the formal Minutes arising from the 29 October 2014 meeting, providing assurance that progress was being monitored against the comprehensive summary of key actions arising from that meeting. Papers A and A1 provided the Minutes of the 26 November 2014 meeting.

Resolved – that the Minutes of the 26 November 2014 Finance and Performance Committee meeting be confirmed as a correct record.

139/14 MATTERS ARISING PROGRESS REPORT

The Committee Chair confirmed that the matters arising report provided at paper B detailed the status of all outstanding matters arising. Members received updated information in respect of the following items:-

(a) Minute 122/14(b) of 26 November 2014 – the Chief Executive advised that he would be undertaking the role of SRO for the EPR project;

(b) Minute 125/14 of 26 November 2014 – the additional training being provided for UHL's clinical staff to respond to revised patient restraint guidance was noted and this item would now be removed from the progress log;

(c) Minute 126/14/2(b) of 26 November 2014 – UHL membership of the Alliance Management Board and Leadership Board had now been confirmed;

(d) Minute 127/14/2(b) of 26 November 2014 – a verbal update on UHL's RTT trajectory would be provided later in the meeting, when the Chief Operating Officer was due to provide a verbal report in the absence of the month 8 Quality and Performance Report (Minute 141/14/1 below refers);

(e) Minute 127/14/3 of 26 November 2014 – in the absence of the Chief Operating Officer at this point in the meeting, it was agreed that he would be invited to provide an update on clinical letters performance during his report on operational performance (Minute 141/14/1 below refers),

(f) substantive reports featured on today's meeting agenda in respect of Minutes 103/14/1(e) and 103/14/5(c) of 24 September 2014 and Minutes 91/14/2(b) and 91/14/3 of 27 August 2014 and these would now be removed from the progress log accordingly. **TA**

Resolved – that the matters arising report and any associated actions above, be noted. **NAMED LEADS**

140/14 STRATEGIC MATTERS

140/14/1 IBM Contract Update

The Chief Information Officer attended the meeting to present paper D, providing an update on performance of the contract with IBM for delivery of core IT services and new projects. Broadly, the contract was delivering performance as anticipated and new stretch targets were being implemented for quarter 4 2014-15 and the first half of 2015-16. 69 members of staff had transferred from UHL to IBM and NTT, 35 members of staff had been retained by UHL, and 34 members of staff had been made redundant. Where any backlogs of work had developed (eg in the business intelligence service), IBM were being held to account to prioritise the backlogs ahead of new projects and additional resources had been provided for this purpose.

Paper D highlighted progress on the key programmes of work for 2014 and 2015. In respect of the Electronic Patient Record (EPR) project implementation, it was noted that separate teams would be established to reduce the risk of this project impacting upon core service delivery. In discussion on paper D, the Finance and Performance Committee:-

(a) sought and received an explanation of the issues affecting the timeliness and accuracy of data warehouse information flows, noting that one of the new SLAs being introduced was for this data to be available from 9am each day as part of the service improvement programme, which also included investment in new hardware;

(b) commented upon the need for intelligent manpower on both sides of the business intelligence service and the fragile nature of this service since 5 key members of UHL's staff had left. The Director of Finance agreed to meet with the Chief Information Officer outside the meeting to consider the arrangements for providing a permanent and robust resolution to the identified issues within the business intelligence service, and **DF**

(c) welcomed the focus on core service delivery and requested clarity regarding the governance structure for overseeing the EPR implementation and the wider IBM contract governance. The Chief Information Officer agreed to provide an update on the IBM governance structure to the Committee in February 2015. **CIO**

Resolved – that (A) the update on the IBM contract be received and noted,

(B) the Director of Finance be requested to meet with the Chief Information Officer to consider and agree a robust solution for the business intelligence service, and **DF**

(C) an update on the EPR project governance and any changes required to the wider IBM contract governance be provided to the Integrated Finance, Performance and Investment Committee in February 2015. **CIO**

140/14/2 University of Leicester Embedded Space within the UHL Estates

The Director of Estates and Facilities introduced an update on progress towards the establishment of a baseline for the space within UHL estates occupied by the University of Leicester (paper F refers). He highlighted the significant difference between the occupancy data held by UHL (6,587m^2) and that reported by the University (2,038m^2). A further meeting was due to be held with the University in January 2015 at which a process and a strategy would be developed relating to formalised occupancy data and an agreed charging mechanism relative to the embedded space on the UHL estate.

Discussion took place regarding the transactional aspects of this data, the apportionment of clinical academic post funding and the importance of maintaining the Trust's strategic relationship with the University. However, it was felt important to address any under-utilised University accommodation to improve UHL's own site utilisation and consider any further scope for shared training facilities. The Director of Finance confirmed his future involvement in the transactional elements of the Trust's relationship with the University and it was agreed that a further update would be provided to the Integrated Finance, Performance and Investment Committee in February 2015. **DEF/ DF**

Resolved – that a further update on University of Leicester embedded space within UHL's estate and the apportionment of clinical academic post funding be provided to the Integrated Finance, Performance and Investment Committee in February 2015. **DEF/ DF**

140/14/3 Interserve Facilities Management Continual Improvement Report

The Director of Estates and Facilities introduced paper G, providing a summary of the proposals put forward by Interserve Facilities Management (IFM) for continuous improvement in the delivery and quality of services provided under the contract (as set out in appendix A). He expressed some disappointment in the level of strategic and tactical analysis demonstrated for service and workforce development and highlighted the scope for further innovation to augment the plan moving forwards (eg more ride-on cleaning machinery and greater alignment between portering activities and resources).

Members discussed some anecdotal evidence of areas requiring improvement, such as hospital reception opening hours which did not align with visiting times, non-availability of wheelchairs in hospital reception areas and a lack of hand soap in toilet facilities. Noting the infection control issue highlighted by the latter example, they queried whether the right key performance indicators were being measured and agreed that under a well-performing contract, a greater focus would be maintained in public-facing areas.

The Chief Executive requested the Director of Estates and Facilities to arrange for a review of reception opening hours to be undertaken to ascertain whether any additional resources would be required to cover the key times of maximum visitor footfall. The outputs of this review would be provided to the Chief Executive outside the meeting. **DEF**

Finally, members commented upon the scope to improve the hospital site maps and directional signs, noting that some significant improvements had already taken place (with input from one of the Trust's patient advisers) and that the Executive Performance Board (EPB) had recently supported a revised "wayfinding" scheme – an update on this workstream was due to be provided to the EPB in March 2015 and new design manuals would be implemented in September 2015.

Resolved – that the Director of Estates and Facilities be requested to review hospital reception opening hours and any additional resources that might be required to **DEF**

expand these to cover visiting hours.

140/14/4 Report by the Director of Estates and Facilities

Resolved – that this Minute be classed as confidential and taken in private on the ground of commercial interests.

141/14 PERFORMANCE

141/14/1 Month 8 RTT and Cancer Performance Report

Due to the December 2014 Finance and Performance Committee meeting being scheduled earlier in the month than usual, the Month 8 Quality and Performance report was due to be considered at the 22 December 2014 Trust Board meeting without prior review by the Finance and Performance Committee or the 15 December 2014 Quality Assurance Committee. Additional paper 2 provided the high level dashboards for the domains of (1) safe, (2) caring, (3) well led, (4) effective, and (5) responsive.

The Chief Operating Officer reported verbally on the following aspects of UHL's month 8 operational performance:-

(a) continued high levels of emergency activity and the associated pressures upon UHL's ED 4 hour waits and other performance indicators;
(b) RTT performance – the non-admitted performance target had been met for November and December 2014, but the admitted target had not been met in November 2014, as previously agreed with the TDA. Work continued to agree a new trajectory for meeting this target, but realistically this would be at least 2 months away;
(c) cancelled operations performance had deteriorated due to the high level of emergency activity;
(d) cancer performance was expected to be regained in December 2014 for 2 week wait, January 2015 for the 31 day targets and February 2015 for the 62 day targets. Whilst the small backlog in the cancer service was reducing, members noted the regrettable incidence of on the day cancellations for cancer surgery (in addition to elective surgery). A discussion on this issue would be held at the 22 December 2014 Trust Board meeting, at which the Medical Director and the Chief Nurse would be invited to comment on the assessment of clinical risks associated with cancellation of cancer operations;
(e) delayed transfers of care (DTOC) levels remained high;
(f) choose and book slot unavailability had reduced to 17% in November 2014 (compared with 20% in October 2014), and
(g) ambulance handover data was expected to improve in quarter 4 of 2014-15 with the implementation of RFID tagging.

Further to Minute 127/14/3 of 26 November 2014 (paper B refers), the Chief Operating Officer updated the Committee on progress with the focused workstream to improve clinical letters performance within the RRC Clinical Management Group. He noted that recruitment to the vacant administrative and clerical posts and roll-out of a specified IT system had achieved a significant reduction and this approach was now being replicated in the remaining CMGs to good effect. A report on the updated clinical letters position (including CMG level data) would be provided to the 29 January 2015 Integrated Finance, Performance and Investment Committee.

Resolved – that (A) the month 8 Quality and Performance report be presented to the 22 December 2014 Trust Board meeting;

(B) the high level dashboards and the verbal information on UHL's operational performance be received and noted, and

(C) a report on the updated clinical letters position be provided to the 29 January 2015 Integrated Finance, Performance and Investment Committee. **COO**

142/14 FINANCE

142/14/1 2014-15 Financial Position to Month 8

The Director of Finance introduced papers I and I1 providing an update on UHL's performance against the key financial duties surrounding delivery of the planned deficit, achievement of the External Financing Limit (EFL) and achievement of the Capital Resource Limit (CRL), as submitted for consideration by the 16 December 2014 Executive Performance Board and the 22 December 2014 Trust Board meetings. He confirmed that November 2014 had been a relatively straightforward month with a favourable in-month movement against plan of £0.3m and a year-to-date deficit against plan of £1.4m.

In respect of the key risks (section 7 of paper I refers), members particularly noted the continued focus upon closing down the revenue and income position for 2014-15, including resolution of technical contractual queries and the development of a revised process for escalation of queries between UHL and the CCGs.

Resolved – that the briefings on UHL's Month 8 financial performance (papers I and I1) and the subsequent discussion be noted.

142/14/2 Cost Improvement Programmes for 2014-15 and 2015-16

Ms E MacLellan-Smith, EY attended the meeting to present paper J, providing the monthly update on CIP performance for 2014-15 and the development of CIP plans for 2015-16. Members noted that the total forecast CIP value for 2014-15 had risen to £48.3m (against the £45m target) and that the value of green RAG-rated schemes was currently £46.5m. Work was continuing to validate performance against the workforce related savings targets of 1% in year and 2% recurrently. The second wave of service reviews in loss-making specialties was underway, in respect of dermatology, general surgery and cardiology. This work was being led by Ms J Bee, one of UHL's Strategic Planners with appropriate support from the EY team and a more detailed progress report would be provided to the Committee in January 2015. One of the key risks (as the Trust entered the winter period) was considered to be the impact of operational pressures upon agency staffing expenditure within the ESM CMG. **COO**

In respect of the £41m CIP target for 2015-16, high level plans had been developed for £33.317m (which represented approximately 80% of the target). The trajectory to achieve 60% of the schemes RAG-rated as green or amber by the end of November 2014 had not been met. However, new deadlines had been agreed for ESM and RRC and the position was expected to improve over the next 2 months. The Committee also received an update on progress with recruitment to the vacant PMO enabling team posts and plans to re-advertise the Head of CIP role.

The Director of Finance and the Director of Strategy commented upon the impact of the draft 2015-16 tariff guidance in respect of CIP delivery for 2015-16 and cautioned against an over-reliance upon income related schemes, counting and coding changes, and increases in activity volumes. The Director of Strategy undertook to prepare a briefing note on this subject for circulation to the CMG management teams. **DS**

Resolved – that (A) an update on the second wave of service reviews be included in the next iteration of the CIP update report, and **COO**

(B) the Director of Strategy be requested to prepare and circulate a briefing note to CMG management teams on the expected impact of the draft 2015-16 tariff guidance upon CIP schemes for 2015-16. **DS**

143/14 SCRUTINY AND INFORMATION

143/14/1 Clinical Management Group (CMG) Presentations

Paper K provided the draft template for CMG presentations to the Integrated Finance, Performance and Investment Committee. In the absence of the Chief Operating Officer at this point in the meeting, the Committee Chair invited members to submit any comments or suggested amendments on the template to her by the end of 22 December 2014. Subsequently, she agreed to contact the Chief Operating Officer outside the meeting to advise him of any changes required. The forward schedule of CMG presentations for 2015 was agreed (as presented in paper K1). **Chair**

Resolved – that (A) the Committee Chair be requested to feedback any comments on the CMG presentation template to the Chief Operating Officer outside the meeting, and **Chair**

(B) the forward schedule of CMG presentations to the Integrated Finance Performance and Investment Committee in 2015 be confirmed (paper K1 refers).

143/14/2 Clinical Management Group (CMG) Performance Management Meetings

Members noted that the November 2014 CMG performance management meetings had been replaced with CMG-Executive dialogue meetings on the draft Annual Operating Plan for 2015-16, consequently no action notes had been submitted for consideration.

Resolved – that position be noted.

143/14/3 Executive Performance Board

Resolved – that the notes of the 25 November 2014 Executive Performance Board meeting (paper L) be received and noted.

143/14/4 Quality Assurance Committee (QAC)

Resolved – that the 26 November 2014 QAC Minutes (paper M) be received and noted.

143/14/5 Revenue Investment Committee

Resolved – that the cancellation of the 10 December 2014 Revenue Investment Committee meeting be noted.

143/14/6 Capital Monitoring and Investment Committee

Resolved – that the cancellation of the 10 December 2014 Capital Monitoring and Investment Committee meeting be noted.

144/14 ANY OTHER BUSINESS

Resolved – that no other items of business were noted.

145/14 ITEMS TO BE HIGHLIGHTED TO THE TRUST BOARD

Resolved – that the following issues be highlighted verbally to the Trust Board meeting on 22 December 2014:- **Acting Chair**

- **Minute 136/14 – Financial Planning Guidance for 2015-16, and**

- **Confidential Minute 140/14/4 – Report by the Director of Estates and Facilities.**

146/14 DATE OF NEXT MEETING AND SCHEDULE OF MEETING DATES FOR 2015

Resolved – that (A) the first meeting of the Integrated Finance, Performance and Investment Committee be held on Thursday 29 January 2015 from 9am – 12noon (venue to be confirmed), and

(B) the schedule of meeting dates for 2015 be confirmed as follows:-

Thursday 29 January 2015;
Thursday 26 February 2015;
Thursday 26 March 2015;
Thursday 30 April 2015;
Thursday 28 May 2015;
Thursday 25 June 2015;
Thursday 30 July 2015;
Thursday 27 August 2015;
Thursday 24 September 2015;
Thursday 29 October 2015;
Thursday 26 November 2015, and
Thursday 17 December 2015.

The meeting closed at 11:32am

Kate Rayns, Acting Senior Trust Administrator

Attendance Record 2014-15

Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
J Wilson (Chair from 29.10.14)	9	8	89%	R Mitchell	9	9	100%
R Kilner (Chair up to 24.9.14)	6	6	100%	P Panchal	2	0	0%
J Adler	9	8	89%	S Sheppard	4	4	100%
I Crowe	9	8	89%	M Traynor	2	2	100%
S Dauncey	2	1	50%	P Traynor (from 26.11.14)	2	2	100%
P Hollinshead	3	3	100%				

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	2	2	100%	M Williams	2	0	0%
G Smith	9	9	100%	D Wynford-Thomas	2	0	0%
K Shields	2	1	50%				

Trust Board Paper L

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

Trust Board Bulletin – 8 January 2015

The following reports are attached to this Bulletin as items for noting, and are circulated to UHL Trust Board members and recipients of public Trust Board papers accordingly:-

- **NHS Trust Over-Sight Self Certification return for the period ended 30 November 2014 (as submitted to the NTDA by 31 December 2014)** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 1,** and

- **Quarterly update on Trust sealings** – Lead contact point Mr S Ward, Director of Corporate and Legal Affairs (0116 258 8721) – **paper 2.**

It is intended that these papers will not be discussed at the formal Trust Board meeting on 8 January 2015, unless members wish to raise specific points on the reports.

This approach was agreed by the Trust Board on 10 June 2004 (point 7 of paper Q). Any queries should be directed to the specified lead contact point in the first instance. In the event of any further outstanding issues, these may be raised at the Trust Board meeting with the prior agreement of the Chairman.

NHS Trust Oversight Self-Certification

In accordance with the Accountability Framework, the Trust is required to complete two self certifications in relation to the Foundation Trust application process. Copies of the self certifications submitted in December 2014 (November 2014 position) are attached as Appendices A and B.

Stephen Ward
Director of Corporate and Legal Affairs

Appendix A

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

Enter Your Email Address * john.adler@uhl-tr.nhs.uk

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 31/12/2014 Reporting Year: * 2014/15

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NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Select the Month *

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors. *	Yes	
2. Condition G5 Having regard to monitor Guidance. *	Yes	
3. Condition G7 Registration with the Care Quality Commission. *	Yes	

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18% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

4. Condition G8
Patient eligibility and selection criteria. *

Yes

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39% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

5. Condition P1
Recording of information. *
Yes

6. Condition P2
Provision of information. *
Yes

7. Condition P3
Assurance report on submissions to Monitor. *
Yes

8. Condition P4
Compliance with the National Tariff. *
Yes

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45% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

9. Condition P5
Constructive engagement concerning local tariff modifications. *

Yes

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73% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

Comment where non-compliant or at risk of non-compliance

10. Condition C1
The right of patients to make choices. *
Yes

11. Condition C2
Competition oversight. *
Yes

12. Condition IC1
Provision of integrated care. *
Yes

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NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: * John Adler

Enter Your Email Address * john.adler@uhl-tr.nhs.uk

Full Telephone Number: * 01162588940 Tel Extension: 8940

SELF-CERTIFICATION DETAILS:

Select Your Trust: * University Hospitals Of Leicester NHS Trust

Submission Date: * 31/12/2014 Reporting Year: * 2014/15

Select the Month *

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

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NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

NHS TRUST DEVELOPMENT AUTHORITY

tda Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY
Indicate compliance. *

Yes

Prev Next Page 3 of 16

16% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance. *

Yes

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22% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance. *

Yes

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28% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Trust Development Authority
Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance. *

Yes

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34% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance. *

Yes

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40% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance. *

Yes

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46% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance. *

Yes

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52% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance. *

Yes

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58% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance. *

Yes

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64% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance. *

Risk

Timescale for compliance: *

31/03/2015

RESPONSE:

Comment where non-compliant or at risk of non-compliance *

The 22 Dec 2014 UHL NHS Trust Board received reports identifying the causes of underperformance on the following indicators, and endorsed the remedial actions being taken to achieve compliance. The individual anticipated compliance dates submitted to the Trust Board are shown against relevant indicators:-

W2 A&E F&F Test (Dec 2014); R1 ED 4-hour waits (Mar 2015); R3 RTT waiting times (admitted) (Mar 2015); R6 RTT 52 weeks+ waits (Dec 2014); R7 6 week Diagnostic test waits (Dec 2014); R8 Cancer-2-week waits (Dec 2014); R10 Cancer 31-day wait for first treatment (Jan 2015); R11 Cancer 31-day wait for second or subsequent drug treatments (Jan 2015); R12 Cancer 31-day way for second or subsequent surgery (Jan 2015); R14 Cancer 62-day wait for first treatment from GP referral (Feb 2015); R15 Cancer 62-day wait for first treatment from Consultant screening referral (Feb 2015), and R23 DTOCs (Mar 2015).

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70% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance. *

Yes

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76% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance. *

Yes

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82% Complete

NHS TRUST DEVELOPMENT AUTHORITY

Quality. Delivery. Sustainability.

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance. *

Yes

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88% Complete

NHS TRUST DEVELOPMENT AUTHORITY

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance. *

Yes

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UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **8 JANUARY 2015**

REPORT BY: **DIRECTOR OF CORPORATE AND LEGAL AFFAIRS**

SUBJECT: **SEALING OF DOCUMENTS**

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1. The Trust's Standing Orders (Standing Order 12) set out the approved arrangements for custody of the Trust's seal and the sealing of documents.

2. Appended to this report is a table setting out details of the Trust sealings for the 2014-15 financial year to date (by quarter).

3. The Trust Board is invited to receive and note this information.

4. Reports on Trust sealings will continue to be submitted to the Trust Board on a quarterly basis.

Stephen Ward
Director of Corporate and Legal Affairs

List of Trust Sealings for Quarter 3, 2014/15

There were no Trust sealings for Quarter 3.